

# Cardiovascular Thoracic Surgical Associates

4600 SW 46th Court, Suite 250  
Ocala, Florida 34474  
Phone (352) 291-2400  
Fax (352) 291-2405

## Referral Form

Referral to: Dr. Brock \_\_\_\_\_ Dr. Gharai \_\_\_\_\_ No Preference \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Male: \_\_\_ Female: \_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient's Phone: \_\_\_\_\_ 2<sup>nd</sup> Phone: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI: \_\_\_\_\_

### Insurance Information

Primary Ins:	Secondary Ins:
Policy #:	Policy #:
Group #:	Group #:
Phone #:	Phone #:
Authorization:	Authorization:
# of visits:	# of visits:
Exp. Date:	Exp. Date:

**\*\*\* NOTE: PLEASE FAX ALL INSURANCE CARDS (front and back),  
PERTINENT RECORDS, and ANY TEST RESULTS TO 291-2405\*\*\***

**IF YOU HAVE ANY RADIOLOGY SCANS PLEASE SEND COPY OF THE  
FILMS WITH THE PATIENT FOR OUR DOCTORS TO REVIEW.**

**THANK YOU FOR YOUR REFERRAL! WE WILL BE IN CONTACT WITH  
THE PATIENT TO SCHEDULE AN APPOINTMENT. IF WE CAN'T REACH  
THE PATIENT OR IF WE ARE UNABLE TO ACCEPT THE REFERRAL WE  
WILL BE IN CONTACT WITH YOUR OFFICE.**