Patient Referral Form for Brittany Henderson, MD, ECNU

Patient Information:

Name: ______________________________ Phone Number: ____________________

Date of Birth: _______________________ Insurance: _________________________

Reason for Referral: ____

Referring Physician/Provider Information:

Name: ____ Date: _______________________

Signature: _______________________________________

Please fax this referral and all available thyroid-related clinic notes, labs, and studies to the Charleston Thyroid Center at (843) 388-5548. We will contact the patient within the next 2-3 business days to schedule an appointment.

www.CharlestonThyroidCenter.com
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