UNIHEALTH SOURCE

Committed to Caring

UNIHEALTH SOURCE REFERRAL FORM

FAX (770) 564-6976 PHONE (866) 514-0662

Please note: Items in Italics with an Asterisk * by them are required fields that must be complete

To: UniHealth SOURCE (Office Name) From: **AFFORDABLE MEDICAL RESOURCES, INC.**

Fax: _____ Date: _____

Phone: _____ Pages: _____

**Patient Name*: _____ **Phone. Number*: _____

**Address*: _____

**Social Sec. Number*: : _____ Date *of Birth* _____

Family Contact _____

Address _____

Home Phone _____ Work Phone _____

Diagnosis _____

Referral Information

FAX: **(770) 509 – 5364**

Referral Source* **AFFORDABLE MEDICAL RESOURCES, INC. **Phone No.* **(770) 321 – 6142**

Physician _____ Phone No. _____

Comments _____

Insurance Information

Medicare _____ * *Medicaid* _____

Private Insurance _____ Other _____

Other Information/ Follow Up _____

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