**Adventist Medical Group - Surgical Care**

**FAX REFERRAL TO: (301) 388-7629**

*(Please print)*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name/Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Clinic contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment Date and Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exam Requested:**

* Surgical consult
* Breast Biopsy
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Indication :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ordering Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adventist Medical Group-Surgical Care**

**Location:**

11886 Healing Way, Suite 404

Silver Spring, MD 20904

**Phone:**

240-637-6000

***PLEASE CONTACT ADVENTIST MEDICAL GROUP-SURGICAL CARE (240-637-6000) AT LEAST 48 HOURS IN ADVANCE IF YOU MUST CANCEL THIS APPOINTMENT.***

**Bill to:**

Primary Care Coalition of Montgomery County

Attention: PCC BCCP

Email: [alyse\_cooper@primarycarecoalition.org](mailto:alyse_cooper@primarycarecoalition.org)

[Nelly\_Velazquez@primarycarecoaition.org](mailto:Nelly_Velazquez@primarycarecoaition.org)

**Please fax consult notes to: \_\_\_-\_\_\_-\_\_\_\_ Attention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**