G. Russell Jennings, M.D.
Pamela Varnagatas, Licensed Aesthetician

Fax: (256) 386-1454 Phone: (256) 386-1450

Patient Referral Form

Please include Office Notes with Referrals – Our office does not accept Medicaid

Patient Information: (Please Complete or Include Demographic Sheet)

PATIENT FULL NAME		
DATE OF BIRTH		SS#
ADDRESS		
CITY, STATE, ZIP		
PHONE #		ALT PHONE #
INSURANCE CARRIER NAME:		
CONTRACT/POLICY #		GROUP #

Referring Provider

NAME		NPI #
PHONE #		FAX #
REASON FOR REFERRAL		

☐ URGENT ☐ ROUTINE

Blood Thinners ☐ YES ☐ NO Does the Patient Smoke/Vape: ☐ Yes ☐ NO

BREAST REDUCTION PATIENT'S ONLY!!!!

- **PATIENT BMI: _____**

  **Due to High Risk of Complications during Surgery, BMI must be 39 or below.

  ** Please include at least 6 months of notes indicating "Conservative Treatment" for ALL Breast Reduction Referrals.