WakeMed North
Physicians Office Pavilion
10010 Falls of Neuse Road, Suite 205
Raleigh, NC 27614
Phone: 919-350-1380
Fax: 919-556-0124

Brier Creek Healthplex
8001 TW Alexander Drive, Suite 200
Raleigh, NC 27617
Phone: 919-235-6455
Fax: 919-350-9876

PROVIDERS: *(Please check if referring to a specific provider.)*

- ☐ Michele Benoit-Wilson, MD
- ☐ Andrea Crane, MD
- ☐ Curt Jacobs, MD
- ☐ Elizabeth Jarvis, MD
- ☐ Amantia Kennedy, MD
- ☐ Netasha McLawhorn, MD
- ☐ Chantel Roedner, MD
- ☐ Unspecified

Cary Medical Park
204 Ashville Avenue, Suite 40
Cary, NC 27518
Phone: 919-235-6460
Fax: 919-350-9815

Morrisville
6102 Grace Park Drive
Morrisville, NC 27560
Phone: 919-235-6480
Fax: 919-350-9821

Holly Springs
101 Cotten Lane, Suite 1
Holly Springs, NC 27540
Phone: 919-235-6456

PROVIDERS: *(Please check if referring to a specific provider.)*

- ☐ Sarah Bowen-Pasfield, MD
- ☐ Anthony Koehler, MD
- ☐ Diana Spahlinger McCarthy, MD
- ☐ Kimberly Munro, MD
- ☐ Jessica Schloesser, MD
- ☐ Unspecified

WakeMed Raleigh Campus - High Risk patients only
Andrews Center
3024 New Bern Avenue
Raleigh, NC 27610
Phone: 919-350-77844
Fax: 919-350-8091

PROVIDERS: *(Please check if referring to a specific provider.)*

- ☐ Michael Armstrong, MD
- ☐ Karen Bash, MD
- ☐ Jenna Beckham, MD
- ☐ Seth Brody, MD
- ☐ Darlene Esper, MD
- ☐ Kathleen Foster, MD
- ☐ Angela Gantt, MD
- ☐ Gregory Mohs, MD
- ☐ Coryell Perez, MD
- ☐ Ritu Sandhu, MD
- ☐ Marili Witt, MD
- ☐ Unspecified

WakeMed Physician Practices
OBSTETRICS & GYNECOLOGY

Request for Consultation

PATIENT DEMOGRAPHIC INFORMATION

Date: ______________________________

Patient Name: ______________________________ Date of Birth: ____________ Race: ______________________

Address: ______________________________ City/State/Zip: ______________________________

Phone *(Please circle preferred number)* Home: ____________________ Cell: ____________________ Work: ____________________

If patient is less than 18 years, Guardian Name: ______________________________ Guardian Date of Birth: ____________

Guardian Email: ______________________________

Does patient/family need an interpreter? ☐ No ☐ Yes If yes, please specify language ______________________________

INSURANCE INFORMATION

Insurance Name: ______________________________

Policyholder's Name: ______________________________ Policyholder's Date of Birth: ____________________

Insurance Phone: ____________________ Policy Number: ____________________ Group Number: ____________________

Medicaid Authorization NPI: ______________________________ Authorized Number of Visits: ______________________________

☐ Care referral authorizations initiated

REFERRAL INFORMATION

Reason for Referral: ______________________________

____

Pertinent History: ______________________________

____

Symptoms: ______________________________

REFERRING PHYSICIAN INFORMATION

Name: ______________________________

Practice Name (if applicable): ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Office Phone: ____________________ Fax: ____________________

Name of Person completing this form: ______________________________

Please include with referral (all that are applicable)

- ☐ History/Office Notes
- ☐ Labs
- ☐ Imaging Studies (patient should bring films or CD)
- ☐ Other pertinent medical records

Thank you for referring your patient to WakeMed Physician Practices - OB/GYN