Oxford Surgical & Bariatric Clinic

OSBC University

Thank you for choosing OSBC for your patient's needs! To begin your referral process, please complete the form below with a copy of insurance card(s) and any pertaining medical records. We will contact the patient within 2-3 business days.

- ☐ Fax completed form to 662-234-4749
- ☐ Attach pertinent medical records, including test results that support the consultation
- ☐ Attach front and back copy of insurance card(s)

PATIENT INFORMATION

NAME: _____ PHONE #: _____

DOB: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY/STATE: _____

PRIMARY INSURANCE

Carrier: _____

ID #: _____

Group #: _____

Policyholder: _____

SECONDARY INSURANCE

Carrier: _____

ID#: _____

Group #: _____

DOB: _____

CONSULTATION REQUEST

DIAGNOSIS: _____

REASON FOR CONSULTATION: _____

APPOINTMENT WITH: ☐ DR. WALKER BYARS ☐ DR. ROBERT MCAULEY ☐ FIRST AVAILABLE

**BARIATRIC SURGERY: PLEASE CHOOSE A PROVIDER AND SEND REFERRAL FORM TO BARIATRIC@OXFORDSURGICAL.COM

REFERRING PROVIDER

PROVIDER: _____ CONTACT: _____

FACILITY: _____ PHONE #: _____

NPI #: _____ FAX#: _____

_____ _____

Referring Provider Signature Date