SURGICAL OFFICE OF
MORGAN & KENNEDY
403 W. Oak St. Suite 204 El Dorado, AR 71730

Office Phone: 870-881-9311 Email: office@mksurgicalclinic.com

GENERAL SURGERY REFERRAL FORM

Please fax completed form to the appropriate number below

REFERRED TO:

☐ **First Available Provider** - New Patients Only (870) 881-8588

☐ **Dr. J. Brandon Morgan**

Fax: (833) 471-4237

☐ **Dr. Thomas Kennedy Jr.**

Fax: (833) 764-6144

Patient Information:

Name: _____

DOB: _____ Male/Female: _____Phone: _____

Address: _____City/State/Zip: _____

Primary Insurance: _____

ID/Policy: _____ Group: _____

Secondary Insurance: _____

ID/Policy: _____ Group: _____

(If Medicaid is primary, be sure to send a Medicaid referral from primary doctor listed with Medicaid)

Referring Doctor/APN: _____

Address:_____

Phone:_____ Fax: _____

Clinic Contact: _____ Date: _____

Please circle what is being ordered: Office Visit Colonoscopy EGD

What are we seeing the patient for? _____

⚠ Screening vs. diagnostic classification is determined by documentation and payer rules. ⚠

If patient has any symptoms, it classifies the procedure as diagnostic and is no longer considered a screening.

Please fax all relevant documents required for patient care including labs, imaging, medication list, etc.