(SC)²
Sickle Cell South Carolina Network
New Patient Referral Form
843-876-0821

- ☐ **Charleston**
- ☐ **Georgetown**
- ☐ **Columbia**
- ☐ **Beaufort**

Patient Name: _____ DOB: _____

SSN: _____Parent(s) name *(If under 18)*: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell # _____ Is it ok to leave detailed message on voice mail? Yes ____ No____

Alternate #_____

Primary Insurance: _____ Employer: _____

Policy Holder: _____ DOB: _____ SS#:_____

Policy #:_____

Group #:_____ Prescription Plan: _____

Pharmacy: _____ Phone # :_____

PCP: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Current Sickle Cell Doctor: _____ ☐ I don't have one

Circle type of Sickle Cell: SS SC Beta Thalassemia O Arab I don't know

Thank you for trusting your patient's care to the team at Lifespan Comprehensive Sickle Cell Center.
Forms may be returned by fax to: 843-876-8519