



**1855 S. Main St. Suite A
Goshen IN, 46526
New Patient Referral Form**

**Vascular Surgery:
Dr. Nathaniel Dew MD and Thomas Etter, MD**

**Vascular & Interventional Radiology:
Dr. Justin Lightburn MD and Dr. Charles Bower MD**

Please complete this form and fax it, along with last office visit notes, lab testing, medication list, **imaging, ultrasound (reports and outside films)** along with a **copy of the patient's insurance card and demographics.**

If imaging is done outside of Goshen Health, please make a copy on a CD or send through PACS. You can either mail a copy attention Sheila Pace or send a copy with the patient.

Patients will not be scheduled until we receive this completed form.

Name: _____ Date of Birth: _____

Phone: _____

Address:

SS#: _____

Insurance: (Primary) _____ (Secondary) _____

Primary Language: _____

Interpreter needed Yes: _____ No: _____

REFERRING PROVIDER: _____

Reason for referral (with ICD—10 codes):

**RETURN FAX TO: (574) 533-7145 ATTENTION: Sheila Pace
Sheila Pace/Heart & Vascular Center Referral Specialist-574-364-3921**