



HABERSHAM SURGICAL SERVICES
REFERRAL FORM
DR. SHEA JONES
DR. PAMELA MCCLOSKEY

638 Historic Hwy Old 441 Suite B Demorest, GA 30535 (P)706-754-8339 (F) 706-754-8460

Date of Referral: _____ Referring Provider: _____

Provider Phone #: _____ Provider Fax #: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Alternate Number: _____

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

(PLEASE FAX A COPY OF THE INSURANCE CARDS IF AVAILABLE)

Reason for Referral/ Possible Diagnosis/ Area of Concern:

Please fax the completed referral form, ID, insurance cards, and any records pertaining to reason for referral to our office directly 706-754-8460.