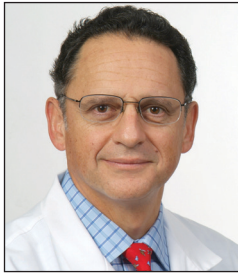


General Surgery

FirstHealth General Surgery offers specialty services in Fayetteville, Raeford, Rockingham, Sanford and Troy. These Pinehurst Surgical Clinic surgeons also provide services in Pinehurst. **To make a referral, call our general surgery referral coordinator at (910) 235-9770.**



Fabian Alzamora, M.D.
(Richmond, Montgomery)



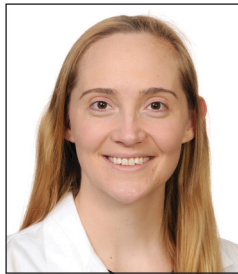
David W. Grantham, M.D.
(Lee)



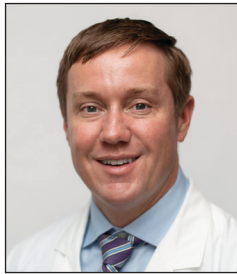
Samuel A. Heathcote, M.D.
(Lee)



Nathan Knapp, M.D.
(Hoke, Richmond)



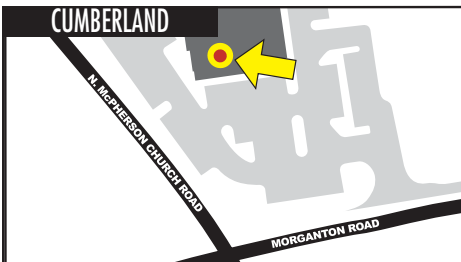
Bailey Sanders, M.D.
(Richmond)



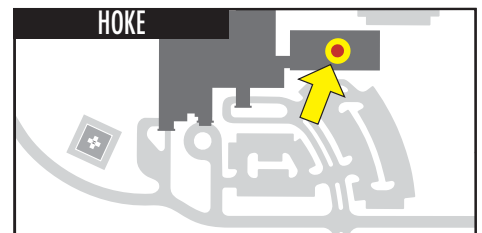
Matthew A. Strode, D.O.
(Hoke, Cumberland)



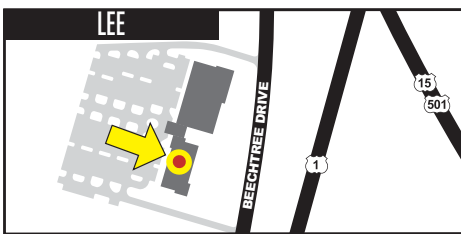
Raymond G. Washington, M.D.
(Lee)



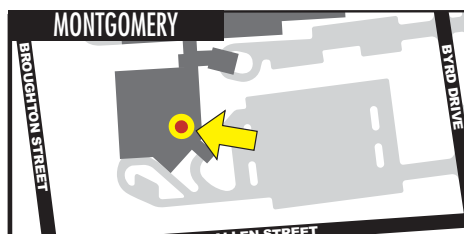
Phone: (910) 215-2507 **Dr. Strode**
Address: 3716 Morganton Rd
Fayetteville, NC 28303



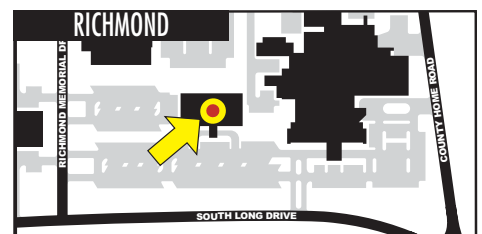
Phone: (910) 215-2507 **Dr. Strode**
(910) 295-0278 **Dr. Knapp**
Address: Physician Offices & Specialty Svcs
6322 Fayetteville Road
Raeford, NC 28376



Phone: (910) 235-4030 **Dr. Heathcote**
(910) 235-2716 **Dr. Grantham**
(910) 295-0882 **Dr. Washington**
Address: 2919 Beechtree Drive, Suite 2100
Sanford, NC 27330



Phone: (910) 235-4024 **Dr. Alzamora**
Address: Medical Arts Building
522 Allen Street, Ste. 103
Troy, NC 27371



Phone: (910) 417-3540 **Dr. Alzamora**
(910) 295-0278 **Dr. Knapp**
(910) 417-3540 **Dr. Sanders**
Address: 921 S. Long Drive, Suite 208
Rockingham, NC 28379

FirstHealth
WITH PINEHURST SURGICAL CLINIC
GENERAL SURGERY

General Surgery

Referral/Consultation Verification

Pinehurst Surgical Clinic
5 FirstVillage Drive, Pinehurst, NC 28374 • (910) 235-9770

Today's Date: _____ Patient Name: _____

Responsible Party _____ DOB: _____

Patient's Address: _____ Patient's Phone Number: _____

_____ Patient's Alt. Phone Number: _____

_____ Patient's Email: _____

Patient's Insurance _____ Insurance Authorization #: _____

Male Female

Appointment Information Needed:

Nature of Problem: _____

Labs, xrays, test performed? Yes No

If yes, what type? _____

Urgency of Appointment: Urgent/Emergent Routine Referral

Referring Physician Name: _____

Telephone number where we may contact you: _____

Appointment referral confirmation fax number: _____

Requested Provider/Dept.: _____

Requested Location: _____

If requested provider is unavailable, may we schedule patient for 1st available provider:

Yes No

Consult:
Opinion or advice sought on patient diagnosis/condition/treatment
Diagnostic or therapeutic treatment may be initiated subsequent to opinion

Referral:
Transfer of care for management of patient
(total care or transfer of care for specified diagnosis/condition/signs & symptoms)

Referring Provider Contact

Scheduler Name _____

Telephone _____

Fax Completed Referral Form to (910) 420-1983