Center for Post-COVID Care Referral

BalladHealth™

○ **STAT** ○ ROUTINE

Reason for Referral: Concern for Post-COVID Syndrome

Date of referral: _____

Fax to 423.282.1216 or send via email to postcovid@balladhealth.org

Primary care physician: _____

Name: _____

Office name: _____

Phone: _____ Fax: _____

*Please attach patient demographic and insurance information.