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Rising Sun, MD 21911  
410-658-6696

## Referral Request

**\*\*\*THIS FORM MUST BE COMPLETED IN ORDER TO  
PROCESS YOUR REQUEST\*\*\***

**Today's Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Contact Phone #:** \_\_\_\_\_

**Insurance:** \_\_\_\_\_

**ID #:** \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_

**Specialist Name:** \_\_\_\_\_

**Facility if applicable:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**NOTE:** Please allow a minimum of forty-eight business hours to process your referral request. **We do not fax referrals so please allow adequate time to pick up the referral, if required.** If you have any questions or need to speak to the referral coordinator, please ask the receptionist or you may call 410-658-6696 extension 15.