



**REFERRAL FAX LINE**  
**Fax: (904) 374-6075**  
**scheduling@medicus4u.com**  
 Scheduling Phone:  
**(904) 503-1065**

www.Medicus4u.com  
 9191 R G Skinner Parkway, Suite 901  
 Jacksonville, FL 32256

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Other#: \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_ Insurance: \_\_\_\_\_ Claim#: \_\_\_\_\_

**REFERRAL INFORMATION**

**DATE OF REFERRAL** \_\_\_\_\_

Physician Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Prior Treatment**

- Hospital
- Chiropractic
- Physical Therapy
- Interventional Pain
- Other \_\_\_\_\_

**Diagnostics Performed**

- MRI/ CAT
  - C-spine
  - T-Spine
  - L-Spine
  - Extremity \_\_\_\_\_
- EMG
- Other \_\_\_\_\_

**Spine Consult**

- Cervical
- Thoracic
- Lumbar

**Extremity Consult**

- Shoulder
- Hip
- Knee
- Other \_\_\_\_\_

**Please attach medical records to referral request. We will call your patient to schedule an appointment as soon as all the information below is received in our office.**

\_\_\_\_ Last two Progress Notes  
 \_\_\_\_ Previous or most recent test **reports/results** related to the condition (MRI, X-RAYS, CT Scans, EMGs, etc.)  
 \_\_\_\_ Imaging CDs (MRI disc necessary at time of consultation. Disc can be mailed prior to or patient can bring to their appointment)

**REQUESTING EMC**



**THANK YOU FOR  
YOUR REFERRAL!**

**Urgency**

- Next Available
- 2-4 Days
- 1-2 weeks
- 2-3 weeks
- 3-4 weeks

**ATTORNEY INFORMATION**

Attorney Name: \_\_\_\_\_ Firm Name: \_\_\_\_\_  
 Paralegal: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_