

Practitioner/Clinic Name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

# Physician/Health-Care Provider's Referral

### Patient Information

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

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

Insurance ID#: \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_

### Referred to

Provider Name: \_\_\_\_\_

Specialty/Type of Treatment: \_\_\_\_\_

### Reason for Referral

Diagnosis codes—ICD-9/10: \_\_\_\_\_

Number of visits (frequency/duration): \_\_\_\_\_

Is the referral for medically necessary treatment? Yes  No

Description of condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Possible precautions due to condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Possible interactions with medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Referred by

Physician/Health-Care Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, a summary report at the end of treatment is appreciated.*

