

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.

