Medical Referral Form

Patient Information

First Name: ______________________ Last Name: ______________________

Date of birth: ______________________ Gender: ☐ Male ☐ Female

Address: ______________________ City: __________ State: __________ Zip: __________

Phone Number: ______________________ Email Address: ______________________

Insurance Information

Insurance Provider: ______________________

Policy Number: ______________________

Group Number: ______________________

Referring Physician Information

Name: ______________________

Address: ______________________ City: __________ State: __________ Zip: __________

Phone Number: __________ Fax Number: __________ NPI Number: __________

Reason For Referral

Referral Specialty: ______________________

Referral Diagnosis (ICD-10 code if available): ______________________

Clinical Summary: ______________________

Additional Tests/Procedures (if applicable)

Please indicate any additional tests or procedures that have been conducted or are recommended:

Specialist/Provider Information (if applicable)

Name: ____________________

Address: ____________________ City: __________ State: __________ Zip: ________

Phone Number: ______________ Fax Number: ______________ NPI Number: ______________

Appointment Information

Preferred Date: ___ / ___ / _____

Preferred Time: ____________

Referring Physician Signature: ____________________ Date: ___ / ___ / _____

Note: Please attach any relevant medical records, lab results, or imaging studies that may assist the specialist in evaluating the patient's condition.