

Practitioner/Clinic Name:

Contact Information

## Physician/Health-Care Provider's Referral

### Patient Information

Patient Name:

Insurance ID#:

Date of Birth:

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.*

