Patient Referral Form

**\_\_\_ Patient Scheduled \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ Unable to reach Patient 5 attempts**

**\_\_\_ Patient Declined Appt.**

Fax to 336-760-5510

**Patient Demographic Information-**

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

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

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

Patient’s Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Provider**

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Referral**

What is the reason for referral? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Imaging and Required Documentation**

Please include the following information if available:

\_\_ Copy of the patient’s insurance card(s) **(front and back copy)**

\_\_ Copies of 2-3 most recent office notes

\_\_ Copies of any X-ray/MRI/CT reports relating to the patient’s pain

\_\_ Copies of physical therapy notes

***Once received and approved our office staff will contact the patient directly to schedule the appointment. If for some reason the referral is not accepted or the patient declines to schedule an office visit, we will notify your office as soon as possible.***

***Please contact us by phone for any urgent referrals at 919-615-0018***

 ***Thank you!***