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FAX REFERRAL

Patient Information:

Patient Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Cell Phone: _____

Insurance Carrier: _____ Claim Number: _____ DOI: _____

* PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PR-2, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. *

- ❑ Consultation & Treatment
  Secondary Treating Physician
  (Medical Management)
- ❑ Consultation Only
- ❑ Transfer of Care/Take Over as PTP
- ❑ Spinal Injection Only
- ❑ Other: _____

- ❑ EMG/NCV
  - ❑ Upper Extremities
  - ❑ Lower Extremities
  - ❑ Both Upper and Lower

Referring Physician: _____ Telephone:_____ Fax:_____