

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.