Physician/Health-Care Provider's Referral

Practitioner/Clinic Name: _____

Contact Information: _____

Patient Information

Patient Name:_____ Date of Birth:_____

Insurance ID#:_____ 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.