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FAX REFERRAL

Feel free to use your own form or simply send:
1) Patient Demographics 2) the last two office notes 3) diagnostic tests

Date: _____

Patient Name: _____ DOB: _____

Patient Phone: _____ SSN: _____

Diagnosis: _____

Special Instructions/Restrictions: _____

Referring Physician:

Doctor/Office: _____ Contact Name: _____
Phone: _____ Fax: _____
Address: _____
City, State & Zip: _____
Email: _____

The above mentioned patient is being referred to you for *(please check all that apply)*:

- Request opinion on/Consultation for (please list): _____
- Diagnostic Procedure (please list): _____
- Therapeutic Procedure (please list): _____
- Medication Management Transfer of care Return to referring physician for continuing care
- Evaluation for clinical trial/Better Health Clinical Research
- Other: _____

Please be sure to include the following information:

- Patient demographics/Facesheet
- Last two office notes
- Any diagnostic test such as MRI, CT Scan, or X-rays
- Copy of insurance card(s) front and back (if possible)

For Workers Comp please include:

- Adjustor name
- Contact phone
- Claim number
- Authorized treating physician

You can download this form at
www.gapaincare.com/referrals

Please fax a copy of this referral form and any applicable medical records.
Patient should bring MRI and/or plain films to consult visit.