MEDICAL REFERRAL FORM

FOCUSTHERAPY
The patient is our focus

RETURN COMPLETED REFERRAL REQUEST FORM TO					
ATTENTION		FAX			
PHONE		EMAIL			
FORM COMPLETED BY		PHONE		DATE	

REFERRED BY			
REFERRING MD		PHONE	
SPECIALTY		FAX	
MD SIGNATURE		EMAIL	
PCP if different		PCP PHONE	

PATIENT INFORMATION			
LAST NAME		FIRST NAME AND MI	
DATE OF BIRTH		FEMALE / MALE	
INTERPRETER REQUIRED?		LANGUAGE REQUIRED	
GUARDIAN NAME		GUARDIAN RELATIONSHIP	
PATIENT'S ADDRESS		CELL PHONE	
		HOME PHONE	
		WORK PHONE	
		EMAIL	
REFERRAL DIAGNOSIS		ICD-9	

SERVICE REQUESTED			
REASON FOR REFERRAL			
PATIENT AWARE OF REASON FOR REFERRAL? IF NOT, PLEASE EXPLAIN.			
SERVICE / SPECIALTY REQUESTED		PHYSICIAN REQUESTED	
TYPE OF SERVICE REQUESTED	☐ CONSULTATION	☐ TRANSFER OF CARE new patient evaluation / management	
ADDITIONAL COMMENTS			

INSURANCE INFORMATION									
AUTHORIZATION REQUIRED?	☐ YES	☐ NO	AUTH #		# OF VISITS		AUTH EXP. DATE		
☐ PPO	☐ HMO	☐ OTHER	INSURANCE PLAN						
INSURANCE ID		MEDICAL GROUP			PHONE #				
INSURANCE HOLDER'S NAME		RELATIONSHIP TO PATIENT			DOB				