PHYSICIAN REFERRAL FORM

Phone: (678) 694-8407 **Fax: (678) 694-8437**

Complete this form and fax to the Fax number above

Referral Date: ____________________

Patient Information

Last Name: **First Name** **Middle Initial**

Date of Birth: **Sex:**

Address: **Apt #:**

City: **State:** **Zip Code:**

Home Phone: **Cell Phone:**

Patient Insurance

Payer: □**Medicare** □ **Medicaid** □ **Other:** ____

Policy#: ______________________

Reason For Referral

□ **Foot Pain** □ **Ingrown Nail** □ **Fracture/Dislocation** □ **Diabetic Foot care** □ **Wound/Ulcer** □ **Bunions**
□ **Foot/Ankle Deformity** □ **PAD** □ **Other:** ____

Additional information included with this form (Fax all available)
□ **H&P** □ **Progress Notes** □ **Medication List** □ **Lab Result (s)**

Referring Physician Information

Physician Name: ____

Phone Number: __________________________ **Signature:** __________________________