Scheduling Line:
813-819-1955

Email: Intake@ASJClinic.com
Fax: 813-280-4855

Nikhil Patel, MD
Rodney Rodrigo, MD
Renato Vesga, MD
Adam Ward, MD
Kamal Patel, MD
Selvon St. Clair, MD
George El-Bahri, DO

PATIENT REFERRAL

☐ **Riverview**
10726 Ketchum Valley Dr.
Riverview, FL 33579

☐ **Tampa**
2727 W MLK Jr Blvd Ste 200
Tampa FL, 33607

☐ **Pinellas Park**
7800 66th St N Ste 305
Pinellas Park, FL 33781

☐ **Odessa**
13543 St Rd 54 Ste B
Odessa, FL 33556

☐ **Spring Hill**
495 Mariner Blvd.
Spring Hill, FL 34609

☐ **Lakeland**
2921 Duff Road
Lakeland, FL 33810

☐ **Lutz**
22953 SR-54 W
Lutz, FL 33549

FORM

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

Patient Phone Number: _____ Last 4 of SSN: _____

Home Address: _____

City: _____State: _____ Zip: _____

Type of Injury:

☐ Auto Accident Insurance Name (PIP): _____ Claim #: _____
☐ Work Comp Insurance Name: _____ Claim #: _____
☐ Health Insurance Insurance Name: _____ Member ID: _____

Attorney Name: _____ Number: _____DOI: _____

Reason for Referral:

☐ Evaluation and Treatment Diagnoses: _____
☐ Procedure
☐ Other: _____

Any Priors:

☐ Urgent Care/Hospital Facility Name: _____
☐ Specialist Facility Name: _____
☐ Chiro/Therapy Facility Name: _____
☐ MRI/X-rays/CT scans Facility Name: _____

REFERRING PHYSICIAN INFORMATION: Physician Name: _____

Date: _____Phone: _____ Fax: _____

Please email to intake@asjclinic.com with last office note and imaging studies