# PATIENT REFERRAL FORM

Thank you for choosing to refer your patient to True Wellness Integrated Medicine. To start the referral process, please complete this form and fax it directly to the clinic.

- Please send brief, pertinent medical records, including test results and imaging, that support the consultation.
- Send a copy of the patient's insurance card (both sides) and a copy of the patient's ID.

Date _____ From _____

No. of pages _____ Title _____

To: _____ Phone _____

Fax _____ Fax _____

## PATIENT INFORMATION

Name of patient _____

DOB _____

Email _____ Phone _____

Parent or caregiver _____

Address _____

City _____ State _____ Zip _____

Insurance _____

## CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9/10 _____

Description: _____

Reason for consultation _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

## REFERRING PHYSICIAN INFORMATION

Referring MD _____ Specialty _____

Phone _____ Fax _____

Primary care provider _____ Phone _____

Signature _____