

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	

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.