OVERTURF
ORTHOPEDICS

Patient Referral Form

Thank you for choosing us to care for your patients' orthopedic needs!

Date:_____ Phone Number: 936-560-2990

# of pages:_____ Fax Number: 936-560-5734

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REFERRING PROVIDER INFORMATION:

Referred by: _____ _____

Phone: _____ Fax:_____ _____

Address: _____

City: _____ _____ ___ ZIP: _____

Form completed by: _____ ___ Phone:_____

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PATIENT INFORMATION (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Phone: _____ ___Gender: o Male o Female

Patient's Address: _____

City/State/Zip: _____

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REASON FOR REFERRAL:

Diagnosis:_____

Reason for Referral: _____

DOCUMENTATION APPRECIATED (Please fax with this form):

- **Recent/relevant typed clinical notes/test results, I.e. history & physical, MRI/Ct/X-rays results**
- **Proof of insurance**
- **Authorization information (if required)**