Scheduling Direct Line: (713)489-1741
Fax: (713)984-8481
Email: Referral@TexasRegionalClinic.com
8301 Katy Freeway | Ste 101 | Houston. Texas 77024

REFERRAL FORM

PATIENT INFORMATION

Today's Date:____________________________ Date Of Inquiry:______/______/______

Patient Name:____________________________ DOB:______/______/______

Address:____________________________

City:____________________________ State:__________ Zip:__________

Home Telephone: (______) ________ - ________ Work Telephone: (______) ________ - ________

Cell Telephone: (______) ________ - ________

Contact Instructions (i.e. Preferred #, Best Time To Reach, etc.): ____________________________

REFERRING PHYSICIAN INFORMATION

Referring Physician Name:____________________________ UPIN/NPI:__________

Clinic Name:____________________________

Contact Phone: (______) ________ - ________ Email:____________________________

INSURANCE INFORMATION or ATTORNEY INFORMATION

Policy Holder / Attorney Name:____________________________

Group# / Attorney Firm Name:____________________________

Patient's ID#:____________________________

Subscriber's ID#:____________________________

Phone: (______) ________ - ________ Fax: (______) ________ - ________

APPOINTMENT INFORMATION

Referral Service Requested (Check all that apply):

- ☐ Orthopedic Consultation
- ☐ Interventional Pain Management + Sports Medicine Consultation
- ☐ Medical Evaluation
- ☐ NeuroSpine Surgeon Consultation
- ☐ Neurologist
- ☐ Other____________________

Physician Specified/Requested:

Body Part Affected:

- ☐ Hand/Upper Extremity
- ☐ Elbow
- ☐ Brain/Head
- ☐ Spine
- ☐ Foot/Ankle
- ☐ Knee
- ☐ Hip
- ☐ Shoulder

☐ Other Body Parts: ____________________________

Diagnosis/Symptoms: ____________________________

Physician Signature: ____________________________

Thank you for entrusting us with your patients. We will contact you regarding this referral.