Patient Referral Form

Date:_____

Patient Name:_____ Date of Birth:_____

Phone: _____ Email Address:_____

Insurance:_____ ID: _____ Group: _____

Referring Office: _____ Referral Email: _____

Referral Phone: _____

Referral request: Coordinated-care evaluation Specific service _____

Records included:

☐ Notes	☐ Authorization, if required	☐ Therapy notes
☐ EMG	☐ Imaging report/access	☐ Other
☐ Operative Records	☐ Labs	

Authorization number: _____ Authorization expiration date: _____

Clinical concern and symptoms:

Additional Symptoms:

☐ Diabetes	☐ Balance difficulty	☐ Sensitivity to light or sound
☐ Numbness	☐ Difficulty walking	☐ Swelling
☐ Tingling	☐ Limping	☐ Joint instability
☐ Burning sensation	☐ Foot dragging	☐ Reduced range of motion
☐ Weakness	☐ Difficulty lifting the foot	☐ Wound or ulcer
☐ Muscle loss or atrophy	☐ Falls	☐ Symptoms extend into arm
☐ Muscle spasms	☐ Headache	☐ Symptoms extend into leg
☐ Reduced grip strength	☐ Migraine symptoms	☐ Symptoms extend into hand
☐ Loss of coordination	☐ Dizziness	☐ Symptoms extend into foot

Submit to approved spineTECH Referral Fax process (409) 898-0177

Submission does not guarantee acceptance or insurance coverage.

Confidential: This document may contain protected health information.