HAND CLINIC

REFERRAL FORM FOR SPECIALTY CARE CENTER

MARNIE PAUL SPECIALTY CARE CENTER
PHONE: 512-324-0137 • FAX: 512-406-6520

TO: APPOINTMENT DESK **FAX TO: 512-406-6520** **NUMBER OF PAGES:** ________________

FROM: ____

PHONE: ________________________ **FAX:** ________________________

PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: ______________

Contact Name: ___________________________ Relationship to Patient: ______________

Contact Telephone: cell ______________ home ______________ work ______________

Patient Address: ____

PHYSICIAN INFORMATION

Referring Physician (*full name*): ________________________________ ❑ MD ❑ DO

Primary Care Physician (*if different from referring physician*): ________________________

Physician Telephone: ________________________ Physician Fax: ______________

MEDICAL INFORMATION

Diagnosis: ___________________________ ICD code: ______________

Reason for Referral: ____

Insurance Company: ________________________________ ❑ HMO ❑ PPO

ID #: ______________ Group Number: ______________ Authorization #: ______________
(If required.)

Area Injured: ______________ ❑ Right ❑ Left ❑ Acute ❑ Chronic

Laceration repair? ❑ YES ❑ NO Date: ______________

DOI: ______________ How: ________________________

Pop heard? ❑ YES ❑ NO Swelling? ❑ YES ❑ NO

Films? ❑ YES ❑ NO Where/When: ________________________

MRI? ❑ YES ❑ NO Results: ________________________

________________________________ Circle where seen: ER Urgent Care PCP Date: ______________
Referring Physician Signature and Date Required

ALL BLANKS MUST BE COMPLETED. PLEASE INCLUDE ANY APPLICABLE HISTORY AND MEDICAL RECORDS

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