

HAND CLINIC

REFERRAL FORM FOR SPECIALTY CARE CENTER

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

TO: APPOIN	IIMENI DE		1 AX 10. 312			UMBER OF PAGES:		
FROM:								
PHONE:					FAX:			
PATIENT IN	FORMATIC	N						
Patient Nan	ne:					Date of Birth:		
Contact Na	me:				Relati	onship to Patient: _		
Contact Telephone: cell				home		work _		
Patient Add	ress:							
PHYSICIAN	INFORMAT	ΓΙΟΝ						
Referring Pl	nysician (<i>fui</i>	II name):					□ MD	□ DO
Primary Car	e Physician	(if different	from referring phy	sician):				
						cian Fax:		
	elephone: _							
Physician Te	elephone: _	ON			Physic			
Physician Te	elephone: _	ON			Physic	cian Fax:ode:		
Physician Te	elephone: _ NFORMATION Referral:	ON			Physic	cian Fax:		
Physician Temperature MEDICAL IN Diagnosis: Reason for Insurance C	elephone: _ NFORMATION Referral: ompany: _	ON			Physic	cian Fax:ode:	_ ПНМО	□ PPO
Physician Temperature MEDICAL IN Diagnosis: Reason for Insurance C ID #:	NFORMATION Referral:	ON		~:	Physic	ode: Authorization #:	_ ПНМО	□ PPO
Physician Temperature MEDICAL IN Diagnosis: Reason for Insurance C ID #:	Referral:	ON	Group Number	∵Left	Physic ICD c	ode: Authorization #:	. □ HMO	□ PPO
Physician Temperature Physician Physicia	Referral: ompany:	ON	Group Number □ Right □ YES	:: Left	ICD c	ode: Authorization #: (If required.) Chronic	. □ HMO	□ PPO
Physician Temperature MEDICAL IN Diagnosis: Reason for Insurance Comparison of the Injured Laceration in the Injured Laceration Injured Laceratio	Referral:ompany: _	ON	Group Number □ Right □ YES	:Left	Physic ICD co	ode: Authorization #: (If required.) Chronic	. □ HMO	□ PPO
Physician Temperature MEDICAL IN Diagnosis: Reason for Insurance Consurance C	Referral: ompany: repair?	ON	Group Number Right YES How: Swelling?	: Left NO YES	☐ Acute Date:	ode: Authorization #: (If required.) Chronic	_ □ НМО	□ PPO

Referring Physician Signature and Date Required

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