Physicians Clinic

Phone: 808.544.3325 | Fax: 808.535.2001

PATIENT NAME: ______________________________

HOME PHONE: ______________________________ CELL PHONE: ______________________________

PRIMARY INSURANCE: ______________________________

☐ TRANSLATOR NEEDED: ______________________________

REASON FOR REFERRAL: ______________________________

☐ NEUROTRAUMA RECOVERY

☐ OSTEOPOROSIS

☐ CONSULT

☐ OTHER: ______________________________

☐ SPASTICITY

☐ PAIN MANAGEMENT

☐ EMG/NCS

REFERRING PHYSICIAN NAME: ______________________________

OFFICE PHONE: ______________________________ OFFICE CONTACT: ______________________________

PLEASE INCLUDE the following with your referral:

☐ DEMOGRAPHICS

☐ LABS/IMAGING

☐ MD NOTES

☐ THERAPY NOTES

☐ IF QUEST, PRIOR AUTHORIZATION (PA)

FOR WORK COMP ONLY:

CLAIM #: ______________________________ DATE OF INJURY: ______________________________

EMPLOYER: ______________________________

ADJUSTER NAME: ______________________________ ADJUSTER PHONE/FAX: ______________________________

CASE MANAGER (IF APPLICABLE): ______________________________