Ace Physician Services

PHYSICIAN LIAISON | PRACTICE MANAGEMENT | PATIENT SCHEDULING

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FAX REFERRAL FORM TO #832-460-3110 ALONG WITH SUPPORTING DOCUMENTATION

PATIENT INFORMATION

Patient Name_____ DOB:_____

Insurance:_____ Patient Phone:_____

Patient Email:_____ Date:_____

REFERRAL TYPE

- ☐ Evaluate and Treat
- ☐ Direct Schedule
- ☐ Private Pay
- ☐ Work Comp
- ☐ DOL
- ☐ Personal Injury
- ☐ Attorney Name/Number_____

REFERRED PHYSICIAN OF CHOICE:

_____

REFERRAL INFORMATION

Referring Entity:_____

Referring Provider:_____

Diagnosis:_____

Priority

- ☐ Urgent (24 hours)
- ☐ High (3-4 days)
- ☐ Routine

Comments:_____

_____

PLEASE PROVIDE THE FOLLOWING INFORMATION

1. Patient demographics, copy of insurance card, and driver's license
2. The two most recent office notes
3. Applicable diagnostic tests
4. Recent history and physical

REFERRAL SPECIALTY — BODY PART

- ☐ Neurosurgeon / Spine _____
- ☐ Orthopedic _____
- ☐ Pain Management _____
- ☐ General Surgury _____
- ☐ Cardiologist _____
- ☐ Chiropractic _____
- ☐ Physical Therapy _____
- ☐ Gastroenterology _____
- ☐ Bariatric _____
- ☐ Plastic Surgeon _____
- ☐ Podiatry _____
- ☐ Gynecologist _____
- ☐ Sleep Study _____

IMAGING

☐ MRI ☐ Ultrasound ☐ X-rays

☐ EMG ☐ CT

☐ Body Part:_____

☐ Other: _____

_____

DME

- ☐ Cervical Brace
- ☐ Lumbar Brace
- ☐ Bone Stimulator
- ☐ Walker
- ☐ Other:_____