RENOVA™

Referral Form

Email: referrals@renovahealth.org
Phone: 972.332.4052 **Fax: 972.332.4075**

REFERRING PHYSICIAN INFORMATION

Date: ______________________ Contact Person: ______________________

Office: ______________________ Contact Phone: ______________________

Physician: ______________________ Fax Number: ______________________

PATIENT INFORMATION

Please complete this form and attach related patient medical records and previous test results.

Patient Name: ______________________ Phone Number: ______________________

Date of Birth: ______________________ Alternate Number: ______________________

Insurance Company: ______________________ Policy# / Claim#: ______________________

Policy Holder Name: ______________________ Policy Group #: ______________________

Adjuster Name: ______________________ Adjuster Phone: ______________________

Other Information: ______________________

REASON FOR REFERRAL

☐ Surgical Consultation / Evaluation / Surgical Clearance / Treatment

☐ Medication / Management / Diagnostic Testing

☐ Other: ______________________

Chief Complaint: ______________________

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Diagnosis: ______________________

Appointment Requested: ☐ 1st Available ☐ STAT

OFFICE USE ONLY

Date: ______________ Time: ______________ ☐ Unable to contact patient

Physician: ______________ Phone: ______________

Comments: ______________________

Thank you for your referral. We will contact your patient for scheduling.