RIMGroup
REBOUND INTEGRATIVE MEDICAL GROUP

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Referral Form

Check: □**Sports & Rehab** □**Psychiatry**

Patient Information

Patient Name: _____ D.O.B.: _____

Patient Phone _____ Group #: _____

Insurance Co. _____ I.D.#: _____

Referral Information

Referring Physician Name & NPI:

_____

Referring Physician Phone #:

_____

Referring Physician Fax #:

_____

REASON FOR REFERRAL (Dx):

_____

_____

Please include:

□ Radiology reports

□ (2) most recent Lab results

□ (2) most recent visit notes

URGENCY: □ Today □ 24 Hrs □ Within 1-2 wks □ Other _____

Referring Physician Signature/Stamp:

_____

□check if more referral pads are needed

For Human Resources Use Only

Date Received: _____ Received by: _____

Thank you for your Referral