COMPREHENSIVE
Spine & Sports Center

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Phone: **(510) 342-5721** Fax: **(510) 342-3260**
Defining Excellence in You

REFERRAL FORM

PATIENT INFORMATION

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Primary Ph #: _____ Secondary Ph #: _____

REASON FOR REFERRAL

Diagnosis/ICD-9 code: _____

❑ Consult Only ❑ Consult & Injections ❑ EMG/NCS ❑ Acupuncture ❑ Alternative Medicine

❑ Wellness Program ❑ Nutritional Counseling ❑ Behavioral Management ❑ Other _____

PATIENT INSURANCE INFORMATION

□ Medicare □ Self-Pay □ PPO □ HMO □ Workers' Compensation

(Please attach copy of insurance cards)

Insurance Company: _____

Authorization Obtained: ❑ YES (Please attach authorization copy) ❑ NO

Workers' Compensation: Claim #: _____ DOI: _____

Adjuster Name: _____ Adjuster Phone #: _____

Interpreter Needed: ❑ YES What Language?: _____ ❑ NO

Referring Physician: _____

Referring Physician Phone: _____

PLEASE FAX TO (510) 342-3260

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