MEDICAL REFERRAL FORM

Referring Physician Information:

Full Name: _____

Medical License Number: _____

Practice Address: _____

Phone: _____

Patient Information:

Full Name: _____

Date of Birth: _____

Patient ID / Medical Record Number: _____

Address: _____

Phone: _____

Referred Specialist / Facility Information:

Specialist / Facility Name: _____

Specialty: _____

Address: _____

Phone: _____

Reason for Referral:

Relevant Medical History and Diagnosis:

Requested Services / Tests / Procedures:

I hereby authorize the referring physician to release any medical information necessary for diagnosis, treatment, or referral purposes. I acknowledge that the referred specialist or facility will provide services as described and that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken. This referral form complies with applicable United States laws governing patient privacy and medical records.

REFERRING PHYSICIAN SIGNATURE

Signature: _____

PATIENT SIGNATURE

Signature: _____