MERCYONE

Clive Physical Medicine & Rehabilitation
12493 University Ave., Ste. 100
Clive, IA 50325

T 515-358-9461
F 515-358-9489

REQUEST FOR REFERRAL APPOINTMENT

Patient's Name: _____ DOB: _____

Best Phone: _____

Insurance: _____ Insurance ID #: _____

Is this Work Comp? ☐ Yes ☐ No If yes, has this been approved? ☐ Yes ☐ No

Interpreter Needed ☐ Yes ☐ No

PLEASE SEND PATIENT DEMOGRAPHIC/COPIES OF INSURANCE

Referring Provider's Name: _____ Office Contact Name: _____

Referring Provider's Phone: ____/____/____ Office Contact Fax: ____/____/____

This consultation request is regarding the following patient diagnosis:

_____

Order for EMG/Procedure:

☐ EMG: ☐ Right Upper ☐ Right Lower ☐ Bilateral Upper
☐ Left Upper ☐ Left Lower ☐ Bilateral Lower

☐ Ultrasound Guided Injection

MUST include the following – our office cannot schedule without documents! Please fax copies of:

- Any diagnostic reports (MRI, CT, X-Ray, ETC.)
- Most recent physician's notes ***PLEASE MAIL IMAGES***

If your patient has had any of the following procedures for the diagnosis listed above, **please check the box and fax supporting documentation** to 515-358-9489:

☐ MRI ☐ X-Rays ☐ CT ☐ EMG ☐ Bone Scan ☐ Medication List

Has the patient previously seen a: ***if yes, please fax documents***

☐ Pain Medicine Specialist if yes, Name of Physician(s): _____

☐ Physiatrist if yes, Name of Physician(s): _____

☐ Physical Therapy if yes, Name of Physician(s): _____

☐ Neurologist if yes, Name of Physician(s): _____

☐ Surgeon (Neuro or Ortho) if yes, Name of Physician(s): _____

Patient Appointment Date ____/____/____ Time ____:____AM/PM

Provider's Name _____

Please fax the completed form to 515-358-9489.