

REFERRAL FORM

Thank you for choosing to refer your patient to IFMAW. To start the referral process, please complete this form and fax it directly to the clinic.

- Send brief, pertinent medical records, including test results and imaging, that support the consultation.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call 253-474-3329

Date	From
No. of pages	Title
To IFMAW practice	Phone
Fax	Fax

PATIENT INFORMATION

Name of patient _____

DOB _____

Home phone _____ Work phone Cell phone _____

Parent or caregiver _____

Address _____

City _____ State _____ Zip _____

Insurance _____

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9/10 _____

Name of MD (if known) _____ Specialty _____

Reason for consultation _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD _____ Specialty _____

Phone _____ Fax _____

Primary care provider _____ Phone _____

Signature _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.