



Please FAX to 715.393.0390

Physician Referral and Consult FAX Line

New Patient/New Problem Referral Form

Today's Date: _____ Referring Clinic Name: _____

Patient Last Name: _____ First Name: _____ M.I.: _____

Patient DOB: _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____

Can we leave a message? Yes No

Alternate Phone: _____

Can we leave a message? Yes No

Work Phone: _____, extension #: _____

Can we leave a message? Yes No

Type of Referral: Self Physician (Name): _____ Phone #: _____

Reason for Referral: _____

Body Part: _____ Second Opinion/WC: _____ Staff Int: _____

Length of Symptoms: _____

How soon does the patient need to be seen?

ASAP 1-2 Weeks 2-4 Weeks Other

Who should we contact to schedule the appointment? YOUR Clinic PATIENT

PMD: _____ Last OV: _____

Diabetic: Yes No Orthotics: Yes No History of MRSA or VRE: Yes No

Reason for Referral/Description of Symptoms/Diagnosis:

	Yes	No	Date	Physician/Provider	Clinic/Hospital	City/State
X-rays / MRI						
Physical Therapy/Chiropractor						
Previous Surgeries/Injections						
Previous Care with any Provider						
Work-Related Injury/ MVA/ Injury / Litigation Pending						
Medical Records to be sent from another facility						

Appointment Date: _____ / Provider: _____ / Location: Wausau Medford Merrill

Revision Date: 062409

Insurance: _____ NP Packet Sent to Patient YES / NO Staff Initials: _____