# IMED Physician Network

Phone (972) 865-4454

## Referral Form

Fax (214) 888-4450

**Date:** _____

**Patient Name:** _____ **S.S # :** _____

**Patient Phone:** _____ **D.O.B:** _____

**Diagnosis:** _____ **D.O.I:** _____

**Referral Doctor:** _____ **Fax:** _____

**Check List**

**I have included with this referral:**

- Demo Sheet
- Insurance Information
- Diagnostics (MRI's, EMG's, X-Rays, CT's, Discograms, Myelograms) Send FILMS with pt, NO CD'S
- Treating Doctor's Clinical Notes
- FCE's, Physical Therapy Evaluations, Psych Related Reports

**Referral Type**

_____ Orthopeadic Consult Region: _____

_____ Neurosurgeon Consult Region: _____

_____ Neurologist Consult Region: _____

_____ Imaging Type Region: _____

_____ Rehab Region: _____

_____ Injection Therapy Region: _____

_____ Pain Medication Management

_____ Eval and Treat Multidisciplinary Program

| Specialist Appointment | |
|---|---|
| Doctor: | |
| Date: | |
| Time: | |
| Contact: | |
| | |

**Additional Notes or Comments**

_____

_____

**Physician Signature:** _____ **Date:** _____

**Print Name:** _____ **Phone:** _____