UPTOWN HEALTHCARE MANAGEMENT INC.

☐ D/B/A East Tremont Medical Center
930 East Tremont Avenue
Bronx, New York 10460
Tel. (718) 764-1633 ~ Fax: (718) 620-6069

☐ D/B/A New York Neuro & Rehab Center
4470 Broadway, Suite #4
New York, New York 10040
Tel: (212) 569-7144 ~ Fax: (212) 569-6320

☐ D/B/A Jerome Family Health Center
1778 Jerome Avenue
Bronx, New York 10453
Tel: (718) 583-3300 ~ Fax: (718) 583-3375

REFERRAL TO AMBULATORY PROCEDURES

☐ DERMATOLOGY ☐ GYNECOLOGY ☐ MUA

☐ GASTROENTEROLOGY ☐ ORTHOPEDICS ☐ PODIATRY

☐ PAIN MANAGEMENT ☐ OPHTHALMOLOGY

1) PATIENT NAME:_____DOB:_____

2) SIDE

☐ B ☐ R ☐ L ☐ X

BILATERAL RIGHT LEFT NO SIDE

3) SITE: _____ Consultation Date:_____

Surgery Date:_ PAT Date: _____

Insurance:_____ Blood Work Date: _____

4) PROCEDURE:_____

5) PROCEDURE TO BE PERFORMED UNDER ULTRASOUND GUIDANCE ▫YES ▫NO

Notes:_____

Surgeon/Provider:_____

Please note patient was medically cleared on: _

SURGEON / SPECIALIST TO COMPLETE ON THE DAY OF THE PROCEDURE:

DATE OF HISTORY AND PHYSICAL : Previous history and physical dated _____

▫ Continues to be essentially correct

▫ is updated with the following _____

_____, MD _____

SURGEON / SPECIALIST'S SIGNATURE DATE

Patient Information

Personal Information

First Name		**Middle Name**	
Last Name		**D.O.B**	
Gender		**Address**	
City		**State**	
Cell Phone #		**Home Phone**	
Work		**Zip**	
Email		**Extn.**	
Attorney		**Case Type**	
Attorney Address		**Attorney Phone**	
Case Status		**SSN**	

Insurance Information

Policy Holder		**Name**	
Address		**City**	
State		**Zip**	
Phone		**Fax**	
Contact Person		**Claim File #**	
Policy #		**WCB Group**	

Accident Information

Accident Date		**Plate Number**	
Report Number		**Address**	
City		**State**	
Hospital Name		**Hospital Address**	
Date of Admission		**Additional Patient**	
Describe Injury		**Patient Type**	

Employer Information

Name		**Address**	
City		**State**	
Zip		**Phone**	
Date of First Treatment		**Chart #**	

Adjuster Information

Name		**Phone**	
Extension		**Fax**	
Email			