Contact Information:
Phone: 360-449-1056
Fax: 360-449-1146

Referral Request

Please Fax this form to (360) 449 – 1146

We will contact the patient directly to schedule an appointment after receiving your fax.

Patient Information:

*Name: ________________________________ *DOB: ______________

*Phone: ________________________________

*Primary Insurance ________________ *Secondary Insurance: _______________________

*REQUIRED INFORMATION

Appointment Type:

___ Orthopedics ___ Physiatry ___ Neurosurgery

___ Next Available ___ Urgent – within one to two weeks ___ Emergent (within 48 hours)

For emergent appointments please call our office at 360-449-1056

___ Specific provider requested: __________________________________

Imaging: ____________________

Diagnosis/Reason for Referral: ____

To ensure timely and appropriate coordination of care please provide the following:

- Relevant Chart Notes
- Diagnostic Imaging (if done)
- Any and all tests or procedures pertaining to diagnosis (For NCV/EMG studies please include numeric data)
- Copy of Insurance Card and information (including workers compensation) and authorization if required

Referring Physician: ____

Referral Coordinator & Contact Number: _____________________________________

Comments: ____