



## Rebound Referral Request

**Please Call For an Appointment or Fax This Form to (360) 449-1090**

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

### Patient Information:

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_

Interpreter Requested: Yes/No

Primary Insurance Carrier: \_\_\_\_\_

Language: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

### Appointment Type:

Orthopedics       Neurosurgery       Physical Medicine & Rehabilitation (Physiatry)

Next Available       Urgent – within one to two weeks

**For emergent appointments (within 48 hours) please call our office at 360-254-6161**

**For emergent appointments at our Portland office please call 503-REBOUND (732-6863)**

Specific physician requested: \_\_\_\_\_

Physician list is available on our website at [www.reboundmd.com](http://www.reboundmd.com)

Please schedule first available appointment with any of the providers

Imaging Available?      Yes\*/No      Type and location done: \_\_\_\_\_

\*We have the ability to view films online for the following locations: Peacehealth SWMC, Vancouver Neurology, Memorial Urgent Care, Vancouver Clinic, Vancouver Radiology, EPIC, Legacy, and Siker Imaging. **If films were not taken at one of these locations please have patient hand carry their films to their appointment.**

Reason for Referral:      Diagnosis: \_\_\_\_\_      ICD – Code (Be Specific): \_\_\_\_\_       Left side       Right side

Consult: \_\_\_\_\_      Evaluate & Treat: \_\_\_\_\_       Bilateral

Additional Information: \_\_\_\_\_

**Our Referral Specialist is available at 360-449-1056 for referrals with multiple complications and to answer further questions.**

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 & Contact Number: \_\_\_\_\_

Referral Coordinator & Contact Number: \_\_\_\_\_

### Contact Information:

Vancouver: (360) 254-6161

Please fax this form and records to: (360) 449-1090

Portland: (503) REBOUND (732-6863)

Office Hours: 8:30 a.m. to 5:00 p.m.

*You will receive a mailed copy of the consult following the appointment.*

*In addition, please indicate if you would like a phone call from the physician consulting on your patient.*