THE FOOT CLINIC

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FAX REFERRAL FORM
PLEASE FAX TO: (256) 489-4455

Referring Physician: ____________________ Contact Person: ____________________

Physician Phone #: ____________________ Fax Number: ____________________

Patient Name: ____________________ Date of Birth: ____________________

Address: ____________________ City/State/Zip: ____________________

Email: ____________________ Patient Phone #: ____________________

Gender (please check): ☐ Female ☐ Male   Alternate Phone #: ____________________

Insurance: ____________________

DX/Comments

Previous Studies: ☐ X-Ray ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ EMG/NCS

*If previous studies exist, please bring films & copy of report(s) to aid in patient evaluation.

EMG/NCS: ____________________

Evaluation/Treatment: ____________________

OFFICE USE ONLY

Appointment Comments: ____________________

To Reorder call Quality Quick 256-533-5633