www.TexasRegionalClinic.com

TRC TEXAS REGIONAL CLINIC

Scheduling Direct Line: (713)489-1741
Fax: (713)984-8481
Email: Referral@TexasRegionalClinic.com
8301 Katy Freeway | Ste 101 | Houston, Texas 77024

REFERRAL FORM

PATIENT INFORMATION

Today's Date: ______________________ Date Of Inquiry: ____/____/____

Patient Name: ______________________ DOB: ____/____/____

Address: ______________________

City: ______________ State: ________ Zip: ________

Home Telephone: (____) ______ - ______ Work Telephone: (____) ______ - ______

Cell Telephone: (____) ______ - ______

Contact Instructions (i.e. Preferred #, Best Time To Reach, etc.): ______________

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: ______________________ UPIN/NPI: ____________

Clinic Name: ______________________

Contact Phone: (____) ______ - ______ Email: ______________

INSURANCE INFORMATION or ATTORNEY INFORMATION

Policy Holder / Attorney Name: ______________________

Group# / Attorney Firm Name: ______________________

Patient's ID#: ______________________

Subscriber's ID#: ______________________

Phone: (____) ______ - ______ Fax: (____) ______ - ______

APPOINTMENT INFORMATION

Referral Service Requested (Check all that apply):

- ☐ Orthopedic Consultation
- ☐ Interventional Pain Management + Sports Medicine Consultation
- ☐ Medical Evaluation
- ☐ NeuroSpine Surgeon Consultation
- ☐ Neurologist
- ☐ Other ______________

Physician Specified/Requested:

Body Part Affected:

- ☐ Hand/Upper Extremity
- ☐ Elbow
- ☐ Brain/Head
- ☐ Spine
- ☐ Foot/Ankle
- ☐ Knee
- ☐ Hip
- ☐ Shoulder

- ☐ Other Body Parts: ______________________

Diagnosis/Symptoms: ______________________

Physician Signature: ______________________

Thank you for entrusting us with your patients. We will contact you regarding this referral.