

Patient Referral Request Form

For Office Use Only

| Order # P - | |
|-------------|----|
| Date rec'd | |
| Checked in | by |
| Date due _ | |
| | |

Referring Physician Information

Phone: 1-917-740-3053 E-mail: info@imrdcorp.org

Patient Information

| irst Name | | | Referred by (MD) | | | |
|---|--------------------|---------|--|------------|-------------------------------------|---------|
| ast Name | | | Affiliation | | Phone () | |
| Birth date (MM/DI | D/YY) | | E-mail | | | |
| Gender | | | Mailing Address:_ | - N | 0((| 0.7 |
| ☐ Female ☐ | Male | | | Number | Street | Apt. # |
| Patient's primary language | | | City & State | Zip | or Postal Code | Country |
| Does the patient need an interpreter? ☐ Yes ☐ No | | | Reason for Referral | | | |
| | e & number) () | | Diagnosis /ICD-10 |) | | |
| Mailing Address: | | | Service/Specialty Requested: | | | |
| | Number Street | Apt. # | Type of Service I | Requested: | | |
| City & State | Zip or Postal Code | Country | | • | ☐ 2nd Opinion ☐ Services ☐ Transpla | |
| | | | Type of Speciality Requested: | | | |
| Documentation Required (Please email with this form) | | | ☐ Allergy&Immunology ☐ Cardiology ☐ Cardiac Surgery | | | |
| | | | \square Colon&Rectal Surgery \square Dental Medicine \square Diabetes | | | |
| Recent/relevant typed clinical notes/test results, i.e. Medical History, Physical Examination, Laboratory Tests, MRI/CT/X-rays results, Medications | | | □ Dermatology □ Gastroenterology □ Gastroenterology □ Gastroenterology □ Gastroenterology □ Hematology □ Neurology □ Neurology □ Neurology □ Redictries | | | |
| Proof of Insurance/Other Financial Arrangements | | | ☐ Oncology☐ Ophthalmology☐ Pulmonology☐ Pediatrics☐ Plastic surgery☐ Rheumatology☐ Thoracic Surgery | | | |
| Authorization information (if required) | | | ☐ Oncology ☐ Urology ☐ Vascular Surgery ☐ Other | | | |

| MD Name (printed) | | |
|-------------------|------------|--|
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