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**Podiatry Referral Form**

***Emily Merriman, DPM***

Phone: (419) 427-1390 Fax: (419) 427-1886

Date of Referral: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Referring Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Demographic Information**

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone: *(Please mark an ‘X’ to indicate preferred contact number)*

Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Information**

Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the patient a diabetic? No Yes\*

\**If yes, please complete the following* ***and send results and/or progress notes****:*

Hemoglobin A1C Last date done \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Value \_\_\_\_\_\_\_

Fasting Glucose Last date done \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Value \_\_\_\_\_\_\_

Last visit w/ PCP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

1. Any recent hospitalization? No Yes\*

*\*If yes, please complete the following:*

Dates of admission \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ through \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Reason for admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. History of coagulopathy? No Yes
2. Any recent imaging studies? No Yes\*

*\*If yes, please complete the following* ***and send report and/or images****:*

Date of imaging \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send the following attachments with this Referral Form:**

* Copy of insurance card(s) - Include front and back of primary and secondary (if applicable)
* Office / progress notes related to clinical information above (including labs, imaging, etc.)

**Fax completed form and attachments to:**

**(419) 427-1791**

***\*\*IF REFERRAL IS URGENT, REFERRING PHYSICIAN OFFICE SHOULD CALL TO SCHEDULE\*\****