Podiatry Referral Form

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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 _____/_____/_____

2. Any recent hospitalization? No Yes*

   **If yes, please complete the following:*

   Dates of admission _____/_____/_____ through _____/_____/_____

   Reason for admission: _____

3. History of coagulopathy? No Yes

4. 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) 427-1886

IF REFERRAL IS <u>URGENT</u>, REFERRING PHYSICIAN OFFICE SHOULD CALL TO SCHEDULE*