Wagner Family Chiropractic SC

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wecare@wagnerchiropractic.net

Referral for Consultation / Transfer of Care

Patient Information

Patient Name:_____ DOB:_____

Address:_____

Phone:_____ ❒ Home ❒ Cell ❒ Work

Insurance:_____Member #:_____Group #:_____

Scheduling Information

Doctor Preference: ❒ Michael R. Wagner DC ❒ Jody M. Wagner DC

❒ Urgent ❒ Next Available Request Date:_____ Appt. Date/Time:_____

❒ Please all patient to arrange appointment ❒ Patient has already been scheduled

(**Will call patient before end of business day**)

Referring Provider:_____ Provider Phone #:_____

Referring Clinic:_____

Address:_____

❒ Consultation (To provide advice and/or recommendations regarding treatment options)

❒ Referral of Care (For evaluation and ongoing care and management of a specified condition)

Referral Information

Relevant History:_____

_____

_____

_____

_____

_____

Additional Comments:_____

❒ X-rays forwarded ❒ Report Forwarded ❒ No X-rays Available Views:_____

Requesting Provider Information

Requesting Provider:_____ Provider's Phone #:_____

Requesting Provider's Signature:_____ Date:_____