APTIVA HEALTH

# PATIENT REFERRAL FORM

Phone: (844) 999.DOCS Fax: (855) 859.0123

www.AptivaHealth.com

☐ **Downtown Louisville**
300 South 13th Street
Louisville, KY 40203
(502) 583.1011

☐ **East Louisville**
3615 Newburg Road
Louisville, KY 40218
(502) 909.0772

☐ **Lexington**
3470 Blazer Pkwy., Ste 350
Lexington, KY 40509
(859) 592.1008

## GENERAL INFORMATION

**Referring Physician:** _____ **Phone:** _____

**Patient Name:** _____ **Phone:** _____

**Date of Birth:** _____ **Address:** _____

**Date of Injury:** _____ **Area of Injury:** _____

**Referral Date:** _____ **Diagnosis**: _____

**Preferred Location:** ☐ East Louisville ☐ Downtown Louisville ☐ Lexington

**Insurance:** _____ **Claim/Group #:** _____

**Why are you referring this patient?** ☐ Motor Vehicle Accident ☐ Workers Comp ☐ Slip / Fall ☐ Health Insurance

☐ Medical Evaluation ☐ Ortho: Extremity Evaluation ☐ Ortho: Spine Evaluation ☐ Concussion Evaluation ☐ Lien

## ADDITIONAL INFORMATION

**Would you like any of the following additional treatments for the patient?**

☐ MRI Region _____ ☐ X-ray Region _____

☐ Epidural Injection ☐ Large Joint Injection ☐ Physical Therapy ☐ EMG

Other _____

_____

_____

**Would you like us to send you the notes for patient visits? If so, how would you like to receive patient notes?**

☐ Yes, email to _____ ☐ Yes, fax to _____ ☐ No, do not send

## SCHEDULING APPOINTMENT

**Is the patient represented by legal counsel?** ☐ Yes ☐ No If yes, please provide contact information below:

Name: _____ Phone: _____ Case Manager: _____

**Do you have any additional requests or comments?**

_____

_____