Hand and Microsurgery Associates

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Referral Request Form

Thank you for the referral. We will be happy to schedule and call your patient regarding the appointment with one of our hand surgeons and will return this form to you with the scheduled appointment date noted at the bottom of this page.

Physician referring to:
_____Cook _____Gowda _____Kobus ____Kovack ____Nappi ____Wilcox

Extremity MRI: **HAND**___left____right **ARM**____left____right **LEG**____left___right

Patient's Name: _____ DOB: _____

Address: _____

Home Phone: _____Cell: _____Work: _____

Insurance & ID number: _____Social Sec._____

Name/DOB of Insured :_____(please fax a copy of the card)

Reason for the consult: _____

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

***If the patient has had any testing related to the requested referral, please fax these reports to our office along with this referral form, including, but not limited to: MRI, CT Scan, EMG/NCV, lab tests, office dictation. If imaging studies have been completed, please have the patient bring the actual films or disc to their appointment.

We appreciate your referral and look forward to assisting you and your patients in the future. If you have any questions, or a patient with what you feel is an urgent situation, please call the office to speak with us directly. Please note we will mail or fax our report to your office once it is available. Thank you.

This appointment has been scheduled for: _____with Dr. _____.

You may use this form as a prescription for MRI with a physician signature.

Physician signature_____