Hand and Microsurgery Associates

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Referral Request Form

Physician referring to: _____**Cook** _____**Gowda** _____**Iorio** _____**Kobus** _____**Wilcox**

Extremity MRI: **HAND**__left___right **ARM**___left___right **LEG**___left__right

Patient's Name: _____ DOB: _____/_____/_____

Home Address: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance & ID number: _____ Social Sec #: _____

Name/DOB of Policy Holder: _____ ***(please fax a copy of front and back of card)***

Reason for the consult: _____

Referring Physician: _____ Office 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.

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

Physician signature _____