Axis Orthopedic & Spine | (214) 592-9955 | Fax (214) 592-9935
appointments@axisortho.com

# Physician Referral Form

Fax to (214) 592-9935 or email a scanned copy to appointments@axisortho.com

## REFERRING PHYSICIAN

PHYSICIAN NAME _____ NPI # _____

PRACTICE NAME _____

PHONE _____ FAX _____ EMAIL _____

## PATIENT INFORMATION

PATIENT FIRST NAME _____ PATIENT LAST NAME _____

DATE OF BIRTH _____ SEX _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ EMAIL _____

PRIMARY INSURANCE _____ MEMBER ID _____

## REFERRAL DETAILS

**URGENCY (CHECK ONE):** ☐ Routine ☐ Urgent (≤ 1 week) ☐ Emergent (same day)

**REASON FOR REFERRAL (CHECK ALL THAT APPLY):**

- ☐ Spine consult
- ☐ Sports medicine
- ☐ Neurosurgery
- ☐ Migraine / headache surgery
- ☐ Post-op follow-up
- ☐ Joint replacement
- ☐ Pain management
- ☐ Orthopedic trauma / fracture
- ☐ Second opinion
- ☐ Other (specify below)

PREFERRED AXIS LOCATION _____ PREFERRED PHYSICIAN _____



## CLINICAL NOTES / HISTORY

Include relevant history, prior imaging, conservative treatments tried, and any contraindications.