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| **REFERRAL FORM** |

**Please complete this form and fax it back to Troy Medical at (833)941-2429.**

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| **Referring Provider Information** |
| **Provider Name:** |  |
| **Phone:** |  |
| **Fax:** |  |

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| **Patient Information** |
| **Patient Name:** |  |
| **DOB:** |  |
| **Phone:** |  |
| **Primary Ins:** |  | **Secondary Ins:** |  |

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| **Reason for Referral** |

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| [ ] Diabetes (specify type below) | [ ] Arthritis (specify type below) | [ ] Migraine |
| [ ]  Insulin Pump Mgmt | [ ] Lupus | [ ] Epilepsy |
| [ ]  Hormone Disorder | [ ] Osteoperosis | [ ] Stroke |
| [ ] Thyroid Disorder | [ ] Gout | [ ] Alzheimer’s/Dementia |
| [ ]  Metabolic Disorder | [ ]  Other Auto Immune | [ ] MS |

**If the reason for referral is not listed, please specify below.**

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| **Other Information** |

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**Please include any applicable visit notes, labs, imaging, or other results when faxing.**