Today's date ___________________________

Legacy Bone Clinic – New Patient Referral Form

Fax completed form and relevant chart notes to 503-413-2427.

Patient Name Birth date

Address

Home Phone Cell/Work Phone SS#

Does patient need an interpreter? YES NO If yes, which language and dialect? _____________

Specific area of injury/Reason for consult: RT LT BIL

Has patient had x-rays? YES NO New X-rays needed?__________________

If yes, please have patient bring X-rays to appointment.

Referring Physician Phone # Fax #

Does patient's insurance require a referral? YES NO If yes, fax referral information with form.

Primary Insurance Carrier____

Member #/Recipient ID #____

Group #____

Address____

Primary holder's name & birth date: ____

Secondary insurance carrier: ____

Member #/Recipient ID #____

Group #____

Address ____

Primary holder's name & birth date ____

Notes ____

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*updated 4/6/09 to include Bob Earl's fax number