AllCare Rheumatology L.L.C
18077 River Avenue, suite # 206, Noblesville, IN 46062
Phone: 317-214-6020 Fax: 317-214-6015
Trinh Tran, M.D.

REFERRAL FORM

Patient's name: ____________________________________D.O.B:___/___/____Phone:______________

Patient's address: ____

____

Referring Physician: ________________________________Phone:_____________Fax:________________

Physician's address: ____

____

Reason for referral: ____

____

Please check/circle the one that apply to the referral:

Evaluate and treat Evaluate and give recommendation

Please fax or mail all pertinent patient's records including lab results, radiology results, office notes, and a copy of patient's insurance card.

Patient's primary insurance: ____

Policy number: ____________________________Group Number: __________________________________

Patient's secondary insurance: ____

Policy number: ____________________________ Group number: _________________________________

Thank you for your kind referral

For office use only

Date referral received: ____/____/____ Date appointment was made: ____/____/____

Appointment date: ____/____/____ Time: ______New patient packet mailed on: ____/____/____

Notify referring office on: ____/____/____ Notify patient on: ____/____/____