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NorthPointe Clinic  
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**Physician Referral Form**

PLEASE USE THIS FORM AS YOUR FAX COVER LETTER

Today's Date: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Reason For Consultation:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Referral Auth #: \_\_\_\_\_  
Accident or Work Comp Related? Yes No

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

**Please fax the following information along with this form to 815-525-4505:**

- MRI, X-RAY, CT, EMG, or any other studies performed related to the patient's condition.
- Recent Office Notes
- Copy of Insurance Card
- Medication List

**Your referral is greatly appreciated. Once we have received the information requested above, our office with contact the patient to schedule an appointment.**

Notes:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_