Fax Referral Form

TODAY'S DATE			
PATIENT NAME		DOB	
PHONE NUMBER		SSN	
PATIENT EMAIL (OPTIONAL)			
PRIMARY INSURANCE			
REFERRAL PROVIDER			
PROVIDER PHONE		PROVIDER FAX	
PROVIDER EMAIL			
DIAGNOSIS AND/ OR REASON FOR REFERRAL			
COMMENTS & QUESTIONS			

REGENERATIVE PAIN TX

- ☐ Back & Neck
- ☐ Headaches
- ☐ Neuropathy
- ☐ Peri-Operative & Transitional Pain
- ☐ Opioid De-Escalation
- ☐ Visceral/Pelvic
- ☐ Oncology
- ☐ Arthritis

SPORTS MEDICINE

- ☐ Urgent Care
- ☐ Joint Clinic
- ☐ Regenerative Therapies
- ☐ Concussion
- ☐ Performance Training
- ☐ Sprains & Strains
- ☐ Fracture management

PSYCHIATRY & LIFESTYLE

- ☐ Medication Mgmt & Counseling
- ☐ Ketamine Infusion Therapy
- ☐ Sexual Regeneration & Therapy

PLEASE INCLUDE THE FOLLOWING:

- ☐ 1. Patient's demographic sheet
- ☐ 2. Copy of insurance card(s) and prior authorization
- ☐ 3. Most recent progress notes
- ☐ 4. Any radiology reports(s): ex. MRI, CT, X-ray, etc.

▸ Please fax all referrals to the Lexington office at (859) 276-5400. Please include this completed form with the requested documents for timely processing. We appreciate your referral and will contact the patient directly to schedule their appointment. Thank you!

Questions? reception@wellwardmed.com

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wellward
Regenerative Medicine

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