Date of Referral: ____/____/____

REFERRAL FORM

TO BE COMPLETED BY
STAFF & FAXED BACK TO
REFERRING DOCTORS OFFICE

Appointment Date ____/____/____

Appointment Time ____:____ AM/PM

NEXUS MEDICAL, PLLC

12277 SW 130th Street | Miami, FL 33186

(833) 321-6682 | Fax: (305) 675-7773

EMAIL / FAX THIS COMPLETED FORM TO: SCHEDULING@NEXUSMEDICAL.NET

Please include most recent office notes, labs and diagnostic testing along with this referral. (305) 675-7773

Referring Physician's Name | Phone | Fax

REQUESTED SERVICE

- ○ **Surgical Evaluation:** ☐ Cervical ☐ Thoracic ☐ Lumbar
- ○ **General Orthopedics:** _____
- ○ **Pain Management:** _____
- ○ **Other:** _____

Diagnosis: _____

Has the patient had any of the following?

Please check all that apply and send reports with this torm.

- ○ **MRI:** ☐ Cervical ☐ Thoracic ☐ Lumbar
- ○ **Pain Management.** ○ **Nerve Conduction**
- ○ **Neurology Evaluation** ○ **Physical Therapy**

TYPE OF ACCIDENT

Auto: _____ Slip/Fall: _____

Date of Accident: _____/_____/_____

If this is an automobile related injury, the PIP has been Exhausted: ○ Yes ○ No ○ Unsure

ATTORNEY INFORMATION

Attorney Name _____

Attorney Phone _____

PATIENT INFORMATION

Patient Name: _____

____/____/____ D.O.B. | ○ *Male* ○ *Female* Gender

Mobile Phone | Home Phone

Social Security

Street

Apt # | City

State | Zip Code

We Appreciate Your Referral!