PATIENT REFERRAL FORM

Phone: (844) 999-DOCS Fax: (855) 859-0123 www.AptivaHealth.com

PREFERRED LOCATION

Louisville - Central	Louisville - Downtown	Louisville - East
Louisville - Middletown	Mount Washington	Elizabethtown
Lexington	Northern Kentucky	Indianapolis
Concussion & Sports Medicine Institute	Lexington Physical Therapy	Lexington Concussion Institute
Lexington Imaging Center	Mental Wellness	

GENERAL INFORMATION

Referring Provider: ______________________ **Phone:** ______________________

Patient Name: ______________________ **Phone:** ______________________

Date of Birth: ______________________ **Address:** ______________________

Date of Injury: ______________________ **Area of Injury:** ______________________

Referral Date: ______________________ **Diagnosis:** ______________________

Insurance: ______________________ **Claim/Group #:** ______________________

Insurance Type: Motor Vehicle Accident Workers' Comp Health Insurance Cash-Pay
Slip / Fall Lien Other ______________________

SERVICES REQUESTED

Orthopedics - Extremity	Orthopedics - Spine	Sports Medicine
Immediate / Injury Care	Concussion	Physical Therapy
Mental Wellness	General Medicine	Telehealth

Imaging - X-ray **Region:** ____________ Imaging - MRI **Region:** ____________

ADDITIONAL INFORMATION

Send visit notes? Yes, email to ______________________ Yes, fax to ____________
No, do not send notes

Patient represented by legal counsel? Yes No

Attorney/Firm: ______________________ **Phone:** ______________________

Case Manager: ______________________

Additional requests or comments:

Please fax completed form to (855) 859-0123 or submit through your Aptiva Health referral contact. Protected health information - handle per HIPAA.