BLAINE
HEALTH & WELLNESS
CHIROPRACTIC | PHYSICAL THERAPY | MASSAGE THERAPY

PATIENT REFERRAL FORM

FAX TO: 763-703-3454

Today's Date:_____ Number of Pages (including this one):_____

REFERRAL SOURCE INFORMATION

Referring Physician/Provider:_____ NPI #:_____

Referring Clinic:_____Phone:_____ Fax:_____

PATIENT INFORMATION

Patient Name:_____ ☐ Male ☐ Female

Date of Birth:_____Type of Insurance:_____

Patient Main Phone:_____ Alternate Phone:_____

REFERRAL INFORMATION

Reason for Referral:_____
(You may fax pertinent information or notes along with this referral form)

☐ Spinal Dysfunction ☐ Radiculopathy ☐ Disc Herniation/Bulge ☐ Shoulder ☐ Hip ☐ Knee

☐ Ankle ☐ Concussion ☐ Pelvic Health

☐ Other:_____

Recommended Treatment Plan:_____

Notes:_____

_____

THANK YOU FOR YOUR REFERRAL

1630 101st Avenue NE, Suite 140
Blaine, MN 55449
Ph: 763-703-3509
Fax: 763-703-3454
www.blainehealth.com