AJ Foot and Ankle Care
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Ste 182

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O: 469.398.1972

PROVIDER REFERRAL FORM

PLEASE **FAX** COMPLETED FORM TO 737.247.7483

Date: _____

Referring Provider: _____

Clinic Phone Number: _____ Clinic Fax Number: _____

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____

Phone Number: _____ Email: _____

Insurance: _____

REASON FOR REFERRAL

FEET:

- ○ Athlete's Foot
- ○ Bunions
- ○ Diabetic Foot Care
- ○ Flat Feet
- ○ Foot Fracture
- ○ Foot Ulcers
- ○ Nerve Pain
- ○ Neuromas
- ○ Neuropathy
- ○ Orthotics
- ○ Osteoarthritis
- ○ Plantar Fasciitis
- ○ Rheumatoid Arthritis
- ○ Warts
- ○ Wound Care

TOES:

- ○ Gout
- ○ Hammertoe
- ○ Ingrown Toenail
- ○ Toenail Fungus
- ○ Other: _____

ANKLE & LEGS:

- ○ Achilles Tendonitis
- ○ Ankle Instability
- ○ Ankle Fracture
- ○ Ankle Replacement
- ○ Shin Splints
- ○ Sprained Ankle
- ○ Tendonitis

Please include:

- Demographic Sheet
- Insurance Information
- History, Physical & Recent Progress Notes
- Prior Test Results (Including ABI if available)

THANK YOU FOR THE REFERRAL!