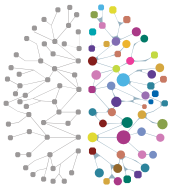
SPECIALTYCARE CLINICS



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REFERRED PATIENT INFORMATION

This form is intended to assure prompt communication with requesting providers. For appointment scheduling, please call the appropriate Specialty Care Clinics location.

IMPORTANT: Fax recent office notes, diagnostic studies, labs and patient demographics to the appropriate office.

CHECK PREFERRED LOCATION

☐ **Farmers Branch**
13988 Diplomat Drive, Suite 100C Farmers Branch, TX 75234

☐ **Plano**
6101 Windhaven Parkway suite 145, Plano, TX 75093

PHYSICIAN AND PATIENT INFORMATION

Patient Name: _____ Date: _____

Patient Telephone: _____ Date of Birth: _____

Referring Physician: _____

Physician Telephone: _____ Physician Fax: _____

Reason for Consultation (diagnosis/chief complaint): _____

URGENCY: ☐ STAT ☐ Within 48 hours ☐ Within 1 to 2 weeks ☐ Next available

WHAT TESTS WERE COMPLETED? (CHECK ALL THAT APPLY):

☐ MRI ☐ X-RAY ☐ EMG ☐ Other: _____

☐ Brain Pathology: _____

☐ Spine Pathology: _____

☐ Peripheral Nerve Pathology: _____

☐ Other Pathology: _____
(For tumors, please reference the Brain & Spine Tumor Referral Form.)

Additional Notes: