

VITRUVIAN
— HEALTH —

REFERRAL FORM

REFERRING PROVIDER

Referring Provider: _____

Practice Name: _____

Phone: _____

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Phone: _____

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

Preferred Location: ☐ Grand Rapids ☐ Ionia ☐ First Available

Requested Physician: ☐ Dr. Camp ☐ Dr. Birgiolas ☐ First Available

REASON FOR REFERRAL

(Please include ICD-10 diagnosis code(s) with the complaint.)

☐ Neck Pain _____

☐ Mid Back Pain _____

☐ Low Back Pain _____

☐ Leg Pain / Sciatica _____

☐ Joint Pain _____

☐ Neuropathy _____

☐ Headache / Migraine _____

☐ CRPS _____

☐ Other _____

PRIOR TREATMENTS

☐ Physical Therapy

☐ Chiropractic Care

☐ Home Exercise Program

☐ NSAIDs

☐ Muscle Relaxants

☐ Neuropathic Medications

☐ Opioids

☐ Epidural Steroid Injection

☐ Medial Branch Block

☐ Radiofrequency Ablation

☐ Spine Surgery

☐ Other

SPECIAL CIRCUMSTANCES

☐ Workers' Compensation

☐ Auto Accident

☐ Attorney Involved

☐ None

DOCUMENTATION ATTACHED

☐ Patient Demographics

☐ Insurance Card(s)

☐ Current Medication List

☐ Most Recent Office Note

☐ Imaging Reports

☐ Procedure Reports

☐ EMG / NCS Results

☐ Operative Reports

☐ Other