Harmony Medical Associates
Envision Empower Excel

11956 Fishers Crossing Drive, Fishers, IN 46038
Tel: 317-842-5555 I Fax: 317-842-5556

PATIENT REFERRAL FORM

REASON FOR REFERRAL_____

_____

REFERRING PROVIDER INFORMATION

REFERRING PHYSICIAN / THERAPIST NAME:_____

PHONE NUMBER:_____FAX:_____

PATIENT INFORMATION

PATIENT NAME:_____

DATE OF BIRTH:_____SS#_____

PATIENT ADDRESS:_____

PATIENT PHONE:_____CELL:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____PHONE:_____
POLICY #_____ GROUP #_____POLICY HOLDER:_____

SECONDARY INSURANCE:_____PHONE:_____
POLICY #_____ GROUP #_____POLICY HOLDER:_____

FOR OFFICE USE ONLY

TODAY_____ 2-3 DAYS _____1 WEEK_____NEXT AVAILABLE_____ OTHER_____

APPOINTMENT DATE: _____TIME: _____

APPOINTMENT CONFIRMED WITH: _____INITIALS:_____

PLEASE FAX TO 317-842-5556

Our staff will contact the patient with an appointment date and time.

Thank you for your referral