



## REFERRAL FAX COVER SHEET

Date: \_\_\_\_\_ Number of Pages (including Cover Sheet): \_\_\_\_\_

To: Shawn O'keefe

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Family Medicine  | <input type="checkbox"/> Men's Health                | <input type="checkbox"/> Biologics   |
| <input type="checkbox"/> Botox Treatments | <input type="checkbox"/> DOT Exams                   | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Suboxone         | <input type="checkbox"/> Orthopedics/Sports Medicine |                                      |

Referring Provider: \_\_\_\_\_

Fax #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Please include patient face sheet with demographics and insurance information.

### FAX REFERRAL TO

Thank you for your referral!

#### CONFIDENTIALITY NOTICE:

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