



FOR REFERRALS:
Phone: (866) 504-1003
Fax: (205) 969-5757
Email: referrals@medwestmail.com

Billing Address: P.O. Box 430226 • Birmingham, AL 35243

PATIENT REFERRAL FORM

Patient Information

Name: \_\_\_\_\_ DOB \_\_\_\_\_ SS#: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Cell Phone: \_\_\_\_\_ Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Information:

Company: \_\_\_\_\_
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PROCEDURE:

- 1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

SPECIAL INSTRUCTIONS:

Followup Date/Time: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

DIAGNOSIS:

\_\_\_\_\_
Claustrophobic? \_\_\_\_\_ Any Metal in Body? \_\_\_\_\_ Allergic Reactions? \_\_\_\_\_

\*\*PLEASE FAX COPY OF REPORT TO MEDWEST AND REFERRING PHYSICIAN\*\*\*\*

Physician Signature: \_\_\_\_\_ Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician Office Contact Name: \_\_\_\_\_

MedWest Use Only:
APPT DATE / TIME: \_\_\_\_\_ CENTER: \_\_\_\_\_
AUTHORIZED BY: \_\_\_\_\_

Workers' Compensation Carrier Information

W/C COMPANY: \_\_\_\_\_ Claim#: \_\_\_\_\_ DOI: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Spoke with: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Authorized by: \_\_\_\_\_ CM Phone: \_\_\_\_\_