CMCL Orthopedics
2600 W. Pleasant Run Rd.
Lancaster, TX 75146
Ph: 888.817.7143
Fax: 888.776.1348

REFERRAL/CONSULTATION FORM

Please complete all sections of this form and FAX it to: (888)776-1348

Referring Provider: _____ Referring Office Name: _____

Referring Provider Phone #: _____ Office FAX #: _____

Primary Care Provider: _____ Today's Date: _____

Person Completing Form: _____ Patient's SSN: _____

Patient's Name (F/MI/L): _____

Patient's Address: _____

Patient's Date of Birth: _____ Patient's Phone #: _____

Patient's Insurance/Auth #'s: _____

Reason for Referral (please be specific): _____

_____

_____

_____

Please Note:

☐ Please include most recent progress notes, X-rays, MRI, CT reports, and procedure reports.

☐ Please include any additional information pertinent to this referral.

☐ We will notify the patient by mail or phone of appointment time and date.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Office Use Only

Provider: _____

Appointment Date: _____

Appointment Time: _____

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