

The Dr. EZ Method: *Referral Form*

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Please fax completed form to **(437) 523-4931** & include **email address** of the patient.

*Incomplete referrals will be returned.

Patient's Name* / DOB* / HC #*	
Contact Number*	
Email* (Helps to Expedite your referral)	
Clinical History & Question* _____ _____ _____ _____ _____ _____ Attached files: _____	
Referring Doctor*	
Billing Number*	
Contact Information & Fax*	
Date * _____	Signature* _____