AMERICAN INJURY NETWORK

7904 E. Chaparral Rd., Suite #A110-508
Scottsdale, AZ 85250
480-688-1894

PATIENT REFERRAL FORM

Patient Information ***Date of Request:*** _____

Patient Name: _____

(Last, First)

Date of Birth: _____ *SSN:* _____

Phone Number: _____ *Email:* _____

Home Address: _____ *City, Zip:* _____

_____

_____

Injury Details

Date of Injury: _____ *Area(s) of Injury*
Be Specific

_____

Treatment Requesting:

_____

(Check One) ☐ *Consult/Report*
☐ *Treatment*
☐ *Second Opinion*
☐ *Follow-up*

_____

Other: _____

Specialty:
(Check All That Apply)

☐ *Orthopedic Surgeon* ☐ *Neurology* ☐ *Dentist*

☐ *Physical Therapy* ☐ *Neurosurgery* ☐ *Foot/Ankle Surgeon*

☐ *Pain Management* ☐ *Anesthesia* ☐ *Diagnostic Imaging*

☐ *Plastic Surgery* ☐ *Chiropractic* ☐ *General Dr. /PCP*

Other: _____

Case Details

Third Party Carrier Name: _____ *Claim#:* _____

*Adjustor:*_____ *Phone#:* _____

Liability Accepted? ☐ *Yes* ☐ *No* *(Check One)* *Policy Limits:* _____ *(If Known)*

First Party Carrier Name: _____ *Claim#:* _____

☐ *Uninsured Motorist OR* ☐ *Underinsured Motorist* *(Check One)* *Policy Limits:* _____ *(If Known)*

Is the Police Report Attached?: ☐ *Yes* ☐ *No* *(Check One)*

Represented by: _____ *Phone#:* _____ *(Atty. Name/Firm)*

Paralegal: _____ *Email:* _____

Contact:

_____

_____

Prior Treating Physician: _____ *Phone#:* _____ *(if applicable)*

Medical Records Available? ☐ *Yes* ☐ *No* *(Check One)* *Medical Records Attached?* ☐ *Yes* ☐ *No* *(Check One)*

Notes/ Comments: _____

_____

_____

Any questions, please contact us at frontdesk@americaninjurynetwork.com