Referral Form for Windhaven Adolescent & Sports Medicine

Date of Referral_____

When would you like your patient seen (within a few weeks, months, no rush)?
_____

****if urgent, please call our office 972-473-8336 and leave a message**

Reason for referral_____
Your name_____
How would you like us to communicate referral findings? **Choose 1 or more:**
Fax _____
Phone_____
Secure email_____

Patient's name _____
Parent's name if patient is living at home_____
Patient's DOB_____
Pertinent health
history_____
_____
_____
Please fax any important labs or notes to 731-201-5756 or send to:
http://sendsafe.to/windhaventeens@yahoo.com

IMPORTANT INFORMATION ABOUT OUR PRACTICE:

1. **We do not allow patients who have been referred to us by another practice to receive any primary care services unless they are discharged from your practice due to age or practice closure.**
2. **We do not file insurance for patients. We have a reasonable & transparent fee-for-service schedule with lower rates that would be charged had a patient not yet met their deductible.**