

# STRATEGIC HEALTH ALLIANCES REFERRAL FORM

Date of Injury \_\_\_\_\_

Case Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

Today's Date\* \_\_\_\_\_

## REFERAL SOURCE\*

(Name) \_\_\_\_\_

(Company) \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_

(E-mail) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

## CONTACT PERSON\*

(E-mail) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

## ATTENDING PHYSICIAN\*

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_

(E-mail) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

## ATTORNEY\* (Plaintiff \_\_\_\_\_ Defense \_\_\_\_\_)

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_

(E-mail) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

## ADDITIONAL INSTRUCTIONS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your signature on this form will serve as authorization to perform the services checked. Please submit medical records with this referral. We will contact you promptly upon receipt of referral. Thank you for your referral and confidence in this office.

\_\_\_\_\_  
(Signature of Authorizing Agent)\*

\_\_\_\_\_  
Date\*

## CLIENT\*

(Notified Yes \_\_\_\_\_ No \_\_\_\_\_)

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_

(Telephone) \_\_\_\_\_

## Parent/ Guardian\*

(Notified Yes \_\_\_\_\_ No \_\_\_\_\_)

(Name) \_\_\_\_\_

(Address) \_\_\_\_\_

\_\_\_\_\_

(Telephone) \_\_\_\_\_

## DIAGNOSIS/ DIAGNOSES\*

\_\_\_\_\_

\_\_\_\_\_

## SERVICE REQUESTED\* (Check all that apply)

Catastrophic/ Major Injury Case Management

Life Care Plan

Opposing Life Care Plan Critique

Medical Cost Projections

Long Term Care Management

Agreed Nurse Case Management

Special Needs Trust

Community Resource Information

Other