

1111 W. 6Th Street Suite 111 | Los Angeles, Ca 90017 | Fax 833-937-7411 | PH 833-437-7411

REFERRAL FORM

**Please Fax Completed Referral Form to** (833-937-7411) or **Email to** [office@serenityhpi.com](mailto:office@serenityhpi.com)

**PATIENT INFORMATION**

|  |  |  |
| --- | --- | --- |
| NAME | | DATE OF BIRTH |
| ADDRESS | CITY | |
| ZIP | PHONE | |
| EMAIL | ALT PHONE | |

**INSURANCE INFORMATION**

|  |  |  |
| --- | --- | --- |
| INSURANCE COMPANY | EMPLOYER | DATE |
| INSURANCE ADDRESS | CITY/STATE | ZIP |
| INSURANCE CASE MANAGER | PHONE | FAX |
| CLAIMS EXAMINER | PHONE | FAX |
| EMAIL | CLAIM NUMBER | DATE OF INJURY |

**TREATING PHYSICIAN INOFRMATION**

|  |  |
| --- | --- |
| TREATING PHYSICIAN | PHONE |
| FAX | EMIAL |

**REFERRAL PARTY INFORMATION: SAME AS PRIMARY TREATING PHYSICIAN**

|  |  |
| --- | --- |
| NAME | DATE |
| ADDRESS | CITY/STATE/ZIP |
| PHONE/FAX | EMAIL |

**FUNCTIONAL RESTORATION PROGRAM: WHERE PATIENT RECOVERY AND WELLNESS IS OUR PRIORITY**