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NEW PATIENT REFERRAL FORM

Thank you for your referral to Dr. Tarasenko.

Please fax/ mail this form together with patient demographics, authorization, MRI, CT scan report & pertinent medical records

Patient Name: (last) _____ (first) _____
DOB: ____ / ____ / ____ Patient SSN: ____ / ____ / ____
Home Phone: _____ Cell: _____ Work: _____
Address: _____

Referred by: (last name) _____ (first) _____ NPI #: _____
Referring Physician Phone #: _____ Fax #: _____
Referring Physician Address: _____

Insurance/Comp Carrier: _____
ID/Claim#: _____ DOI/Group #: _____
Adjuster: _____ Phone: _____ Fax: _____
Address: _____
Authorization: _____

Reason for referral: Evaluation Only Evaluate & Treat Routine ASAP
 Procedure Suboxone detox Medication management

Special Instructions: _____
