# Referral Form

☐ To: Alarus Beaver Dam • 111 Warren St., Suite 2 • Beaver Dam, WI 53916 • 920.219.4440 • Fax 920.219.4553

☐ To: Alarus Grafton • 1971 Washington St., Suite 200 • Grafton, WI 53024 • 262.377.6276 • Fax 262.377.6289

☐ To: Alarus West Bend • 1622 Chestnut St. • West Bend, WI 53095 • 262.306.9800 • Fax 262.306.9802

Please fax this form to the appropriate Alarus clinic or email the form to alarusdocuments@gmail.com

## Referring Facility/Physician

| | | |
|---|---|---|
| **Facility** | | |
| **Physician/Person Referring** | | |
| Address | | Signature: |
| Telephone No: | | |
| Email: | | |

## Patient Contact Details

| | | | |
|---|---|---|---|
| FULL NAME | | | |
| Date of Birth | | | |
| Home Address: | | | |
| **Contact Details** | | | |
| Home Telephone | | | |
| Mobile | | Email: | |
| **Insurance Information**<br>Insurance Name ID Number Group Number<br>Insurance Phone Number | | | |
| **Reason for Referral** | | | |

**Clinical Information**

Symptoms:

UA Needed? ☐ Yes ☐ No How often?

Has the patient been to any other facilities in the past 30 days?

Present medication/Suggestions:

Past medication/Suggestions:

Past Diagnosis:

Relevant medical history:

Relevant family medical history: