Referred to:

Joseph J. Schifini, M.D.

600 South Tonopah Drive, Ste. 240, Las Vegas, Nevada 89106
(702) 870-0011 Fax: **(702) 870-1144**

Referral:

Patient Name: _____ DOB: _____

Phone#: _____ Cell/Work#: _____ SSN#: _____

Workers Compensation Information:

W/C Name: _____ Body Part: _____

Adjuster: _____ Phone: _____ Fax: _____

Date of Injury: _____ Claim#: _____

Insurance Information:

Primary Insurance: _____ Phone#: _____

Secondary Insurance: _____ Phone#: _____

Lien Information:

Attorney Name: _____ Phone#: _____

Fax#: _____

Treatment Request: (Please circle one)

•TOC • Consult Only • Consult & Treat • 2nd Opinion • IME •

Referring Physician: _____ Ph: _____ Contact: _____

Would you like a fax, regarding patient's appointment date and time? ☐ Fax: _____

Please fax most recent clinical notes and radiology reports to 870-1144
(Also include patient demos and insurance information)

Patient scheduled: ____/____/____@ A.M. / P.M.

Comment: _____