ALLMED
MEDICAL CORP

FAST TRACK SCHEDULING
Direct Fax: (916) 400-9264

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BOARD CERTIFIED IN INTERNAL MEDICINE
2485 Sunrise Blvd., Suite A
Rancho Cordova, CA 95842
Phone: (916) 281-2251

INTERNAL MEDICINE REFERRAL

Date:

Type of Service Requested: ☐ Consultation ☐ Evaluate & Treat ☐ Medical Clearance
☐ Other (please specify): _____
Reason for Referral: _____
Diagnosis/ ICD:
Service/Specialty Requested: _____

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____ Medical Group: _____
Phone: _____ Fax: _____ PCP: _____
Address: _____ City: _____ Zip: _____
This form completed by: ____ Phone: _____

PATIENT INFORMATION (Please provide copy of patient demographics/face sheet):

Last Name: _____ First Name: _____ MI: _____
DOB: _____ Phone: _____ ☐ Female / ☐ Male
Address: _____
City/ Zip: _____
Insurance: ☐ W/C ☐ Lien ☐ Medpay ☐ PPO ☐ Other
Attorney Name: _____ Phone: _____ Fax: _____
Primary Insurance: _____ ID #: _____ Group #: _____
Work Comp Carrier Claim #: Date of Injury:
WC Adjuster: Phone #: Fax #:

Needs interpreter? ☐ No/ ☐ Yes: Language

DOCUMENTATION REQUIRED (Please fax with this form):

☐ Recent/relevant typed clinical notes/test results, I.e. history & physical, MRI/Ct/X-rays results
☐ Proof of insurance
☐ Authorization information (if required)