STRATEGIC HEALTH ALLIANCES REFERRAL FORM

Date of Injury _____

Case Number _____

Date of Birth _____

Today's Date* _____

REFERAL SOURCE*

(Name) _____

(Company) _____

(Address) _____

_____

(E-mail) _____

(Phone) _____ (Fax) _____

CONTACT PERSON* _____

(E-mail) _____

(Phone) _____ (Fax) _____

ATTENDING PHYSICIAN*

(Name) _____

(Address) _____

_____

(E-mail) _____

(Phone) _____ (Fax) _____

ATTORNEY* (Plaintiff _____ Defense _____)

(Name) _____

(Address) _____

_____

(E-mail) _____

(Phone) _____ (Fax) _____

CLIENT* (Notified Yes _____ No _____)

(Name) _____

(Address) _____

_____

(Telephone) _____

Parent/ Guardian* (Notified Yes _____ No _____)

(Name) _____

(Address) _____

_____

(Telephone) _____

DIAGNOSIS/ DIAGNOSES*

_____

_____

SERVICE REQUESTED* (Check all that apply)

- ☐ Catastrophic/ Major Injury Case Management
- ☐ Life Care Plan
- ☐ Opposing Life Care Plan Critique
- ☐ Medical Cost Projections
- ☐ Long Term Care Management
- ☐ Agreed Nurse Case Management
- ☐ Special Needs Trust
- ☐ Community Resource Information
- ☐ Other

ADDITIONAL INSTRUCTIONS

_____

_____

_____

_____

_____

_____

Your signature on this form will serve as authorization to perform the services checked. Please submit medical records with this referral. We will contact you promptly upon receipt of referral. Thank you for your referral and confidence in this office.

_____

(Signature of Authorizing Agent)* Date*