REVIVE HEALTH CENTER
SPINE & JOINT

813.535.7960 813.370.0139
TAMPA 4019 W Waters Ave, Suite B, Tampa FL 33614

PATIENT REFERRAL FORM

PATIENT INFORMATION:

PATIENT NAME: ______________________ PHONE NUMBER: ______________________

DATE OF BIRTH: ______________________ DATE OF ACCIDENT: ______________________

PATIENT ADDRESS: ____

REFERRING PHYSICIAN: ____

PHYSICIAN PHONE NUMBER: ______________________ PHYSICIAN FAX NUMBER: ______________________

ATTORNEY: ____

ATTORNEY PHONE NUMBER: ______________________ ATTORNEY FAX NUMBER: ______________________

DOES THE PATIENT HAVE MRI'S? ☐ NO ☐ YES (If yes, please send the MRI report with the referral.)

PIP INSURANCE CARRIER: ____

INSURANCE PHONE NUMBER: ______________________ INSURANCE FAX NUMBER: ______________________

POLICY NUMBER: ______________________ CLAIM NUMBER: ______________________

PIP ADJUSTER: ____

ADJUSTER PHONE NUMBER: ______________________ ADJUSTER FAX NUMBER: ______________________

BILLING ADDRESS: ____

REASON FOR VISIT:

☐ Interventional Pain Management ☐ Spine ☐ Orthopedic ☐ Final With Impairment Rating

Complaints: ☐ Neck ☐ Back ☐ Shoulder ☐ Knee ☐ Other: ______________________

REV 1/2025

EMAIL COMPLETED FORM TO:
SCHEDULING@REVIVESPINEJOINT.COM
OR FAX **813.370.0139**

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