PACIFIC
Sports and Spine

REFERRAL FORM

Fax to (541) 780-6645

**** * PLEASE COMPLETE REFERRAL TO PREVENT * ***
DELAYS IN SCHEDULING

REFERRING PROVIDER

Physician:_____ PCP:_____

Phone:_____ Phone:_____

Chief Complaint:_____ Urgent Referral? ☐ Yes ☐ No

Referring to:

☐ **Dr. Gregory A. Moore, MD** ☐ **Dr. Gregory M. Phillips, MD**

PATIENT INFORMATION *All Patient information is required to prevent any delays in scheduling.*

Name:_____ DOB: _____ SS#: _____

Mailing Address: _____

Home Phone: _____ Cell: _____

PLEASE INCLUDE ANY IMAGING REPORTS AVAILABLE *within Last 12 Months*

☐ **Schedule an MRI at PACIFIC SPORT AND SPINE Imaging**

To schedule an appointment, please fax ORDER to (541) 780-6645

☐ **Have current imaging studies available**

MRI Date performed:_____ Facility:_____

CT Date performed:_____ Facility:_____

X-RAY Date performed:_____ Facility:_____

WORKER'S COMPENSATION INJURY, MVA OR OTHER LIABILITY

Company:_____ DOI:_____

Adjuster's Name:_____ Phone:_____

MEDICAL HEALTH INSURANCE IS REQUIRED WITH ANY WC OR MVA REFERRAL

Health Insurance Company:_____ ID # _____

REV010119

FAX (541) 780-6645

Office Phone: (541) 780-6654