UNIVERSITY OF COLORADO HOSPITAL
THE CENTER FOR
INTEGRATIVE MEDICINE
Anschutz Outpatient Pavilion - 1635 Aurora Ct.- Aurora, CO 80045 - Phone: 720.848.1090 - Fax: 720.848.1277

Patient Referral Form **Patient Name:____________________**

The following information is required to schedule your patient with The Center for Integrative Medicine. Please return the completed form and any pertinent medical records by **fax to 720-848-1277**.

What are you referring the patient for?
Please Select:

☐ Physician Integrative Medicine Consultation
☐ Behavioral health/Psychology
☐ Chiropractic Therapy
☐ Pharmacist/Herbal Supplement Consult
☐ Nutritional and Dietary Counseling
☐ Biofeedback
☐ Acupuncture
☐ Massage Therapy

Referring Physician:
Physician Name: ____
Address: ____
City: ____________________________ State: ___________Zip: _______________________
Phone: __________________________Fax: ____

Patient Diagnosis/Symptoms: ____
Please include ICD-9 code and description

The following information will be necessary in order to process this referral and obtain authorization for the visit. You may provide this information by sending a copy of the patient's demographics & insurance information (face sheet) or by completing the section below.

Patient Information:
Name: (first, middle, last) ____
Address: ____________________________________ City: ______________________ _____
State:______ Zip:__________ Sex: ____ M _____ F
Phone Numbers: Home _______________ Cell ________________ Work ______________
DOB: ______________________ Social Security #: __________________________________

Insurance Information: (Either complete this section OR send a copy of the front & back of the insurance card)
Insurance Company: ________________________ Insurance Phone: ___________________
Name of Insured (if other than patient):____________ ______________________________
Insured's DOB: ________________ Insured's Social Security #: _________________________
Insurance ID #: ___________________________________Group #: ____________________

If applicable, please check: __ Motor Vehicle Accident __ Workers' Comp
Date of Accident/Injury ____-____-_______ Claim # ________________