ADROITA
Care. Simply Different.

Referral to Adroita

Referring Physician information				
Referring Physician's Name				Date (Month DD, YYYY)
Office Address				
City		State	ZIP Code	Phone Number
Fax	Primary Care Physician			

Patient Information				
Patient ID	Patient Name (First, Middle Initial, Last)			Sex ☐ Male ☐ Female
Address				County (Optional)
City		State	ZIP Code	Birth Date (Month DD, YYYY)
Home Phone	Alternate Phone (Cell or Work)	Guarantor's Name (If Applicable)		
Maiden Name (If Applicable	Spouses Name (If Applicable)			

Patient's Insurance Information (If Available)

Insurance Company: Member ID:

Address: Group #: Co-Pay:

Appointment Request
Reason for Referral/symptoms/diagnosis (please be specific). Please submit any pertinent medical records.
Special Date or Time Requested

Thank you for referring your patient to Adroita. We will notify you once the appointment has been scheduled.

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