State of Franklin
HEALTHCARE ASSOCIATES™

Foot and Ankle Specialists Referral Form

Patient Name:______________________________ Sex: M / F Age:______ D.O.B:______________

Home Address: ____

City:____State:_______ Zip:_________________

Home Telephone Number: ( ) _______-____________

Mobile Telephone Number: ( ) _______-____________

E-mail: ___________________________@________________

INSURANCE:

Primary Insurance Company:____

Secondary Insurance Company: ____

Subscriber ID: _______________________________________ Group #: ______________________

Responsible Party Name: ____ D.O.B:______________

Relationship to Patient:________________________________ Phone: ( ) _____-____________

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REASONING FOR REFERRAL

Referring Physician: ____

Referring Physician Signature: _____________________________________

What condition(s) is the patient being referred for? __________________________

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Please fax this form and all supporting documentation including any relevant diagnostics, as well as the most recent office visit, to (423) 232-8576