TRUFORM
Texas Functional Health Centers | Dallas, TX

PHYSICIAN REFERRAL FORM

Fax to 214-269-7547 | Phone (469) 334-0624

REFERRING PROVIDER

PROVIDER NAME

CREDENTIALS / SPECIALTY

PRACTICE / CLINIC

NPI

PHONE

FAX

EMAIL

PATIENT

PATIENT NAME

DATE OF BIRTH

PHONE

INSURANCE / PAYER

REASON FOR REFERRAL

PRIMARY CONCERN (CHECK ALL THAT APPLY)

- ☐ Low back pain
- ☐ Neck pain
- ☐ Sciatica / radiculopathy
- ☐ Headache / migraine
- ☐ Disc injury
- ☐ Post-MVA / whiplash
- ☐ Shoulder
- ☐ Knee / hip
- ☐ Peripheral neuropathy
- ☐ Postural dysfunction
- ☐ Gait / balance
- ☐ Functional / metabolic

RELEVANT HISTORY / IMAGING / CURRENT TREATMENT

PRECAUTIONS OR CONTRAINDICATIONS

REQUESTED

- ☐ Evaluate and treat
- ☐ Evaluate and report back
- ☐ Co-manage
- ☐ Second opinion

REFERRING PROVIDER SIGNATURE

DATE

PLEASE FAX COMPLETED FORM TO 214-269-7547
This form contains protected health information. Fax or deliver directly — please do not send patient details by unsecured email or web form.
Questions about a referral? Call (469) 334-0624 and ask for the clinical team.
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