

## PATIENT REFERRAL FORM

**Exam Can be Done from Patients' HOME on their SMARTPHONE**  
**We Emphasize the Importance of Continued Rehabilitative Care at YOUR Clinic**

☐ Telehealth Visit    ☐ Appointment in Tampa office

Please note, fields marked \* required for scheduling.

**Please Fax and/or Email referral form to (813) 580-7161 or [info@EZemc.com](mailto:info@EZemc.com)**

**For your convenience, referrals can also be easily uploaded on the Physician Portal**

### Patient Details

Last Name*		Referral Date:	
First Name*		<input type="checkbox"/> Male*	<input type="checkbox"/> Female*
Date of Birth*		Date of Accident	
Patient Telephone*			
Patient's Email			
Attorney		Attorney Tel:	

### Insurance Details

Insurance Company	
Policy Number	
Claim Number	
Insurance Telephone	

### Referring Facility

Prefer Reports: ☐ Faxed    ☐ Secure Email    ☐ **Physician Portal**

Clinic Name	
Physician Name	
Telephone (Work)	
Fax	
Email address	

### Imaging Details

Note: Imaging may be helpful when making an EMC determination

<input type="checkbox"/> Patient has NOT had imaging	Patient completed: <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> CT		
Name of Imaging Facility			
Facility Telephone		Facility Fax	
<b>If Available Please Fax and/or Email Imaging Reports with referral form to (813) 580-7161 or <a href="mailto:info@EZemc.com">info@EZemc.com</a></b>			