



PATIENT REFERRAL FORM

INSTRUCTIONS

When complete please **fax** directly to Electromed, Inc. at **888-901-7373** or 866-758-5077. If available, please attach **signed Patient Agreement Form**. If available, please attach **patient face sheet** with insurance information.
 Questions? Please call **Electromed, Inc.** at 800-462-1045.

For Office Use Only

Date Received: _____
 ID #: _____
 Sales Rep: _____

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (Middle Initial) _____
 Street Address: _____
 City: _____ State: _____ Zip code: _____
 Home phone: _____ Work phone: _____ Cellular: _____
 Date of Birth: _____ SS#: _____ M _____ F _____
 Height: _____ Weight: _____ SmartVest® size (if known from use in clinic): _____
 Guardian/relationship: _____ DX code: _____ Diagnosis: _____

INSURANCE INFORMATION (Primary) - Will accept printout of insurance information

Primary Insurer: _____ Telephone: _____
 ID #: _____ Group #: _____ Policy #: _____
 Insured: _____ SS#: _____ Insured's DOB: _____
 Relationship to insured: _____ Insured's employer: _____

INSURANCE INFORMATION (Secondary) - Will accept printout of insurance information

Secondary Insurer: _____ Telephone: _____
 ID #: _____ Group #: _____ Policy #: _____
 Insured: _____ SS#: _____ Insured's DOB: _____
 Relationship to insured: _____ Insured's employer: _____

HEALTHCARE TEAM (including PRESCRIBING PHYSICIAN)

Clinic Name: _____
 Clinic Contact Name: _____ Contact telephone #: _____
 Clinic Contact E-mail: _____ Clinic Fax #: _____
 Physician Name: _____ Physician telephone#: _____