Patrick D. Griffith, M.D.
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(816)221-4114

Patient Referral Form - Complete and Fax to (816) 346-7135

Patient Information	
Name:	**Date of Birth:**
Address:	
City, State, Zip	
Home Phone:	**Work or Cell Phone:**
Social Security No.	

Insurance Information	
Primary Insurance: **Policy No.**	**Claims Address:**
Group No.	**Cardholder-Insured:**
Phone No.	**Date of Birth:**
Referral or Authorization No.	
Secondary Insurance: **Policy No.** **Group No.**	**Claims Address:** **Cardholder-Insured:**
Phone No.	**Date of Birth:**

Worker's Compensation Claim?	**Yes___ NO___**
If yes, please supply carrier and mailing address per above and complete below.	
Nurse Case Manager:	**Phone No.** **Fax No.**
Adjuster:	**Phone No.** **Fax No.**
Claim No.	**Date of Injury:**

PCP and Referring Doctor		
Referring Doctor:	**Phone No.**	**Fax No.**
PCP Name:	**Phone No.**	**Fax No.**

Primary Complaint or Patient's Diagnosis		**Included**
Patient Complaint:		
Please include the following with the Patient Referral:	**Imaging Reports (MRIs, CT, X-Ray, Bone Scan)**	
	Progress Notes	

Fax completed form to (816) 346-7135 or call (816) 221-4114 to schedule an appointment.