Telemedicine Referral

Texas Medical Association
Physicians Caring for Texans

Patient name _____ Date _____

Contact name _____ DOB _____

Phone numbers:

☐ Home _____ ☐ Mobile _____

☐ Work _____ ☐ Other _____

Address _____ Email _____

Insurance

Primary insurance _____ Policy # _____

Secondary insurance _____ Policy # _____

Pharmacy

Preferred pharmacy name _____ Phone _____

Location _____

Notes

Reason for referral _____

_____

_____

See attached summary of the patient's medical history, allergy, and medication information. Should you require additional information, please contact our office.

Referring physician name _____ Phone _____

Address _____

Referring physician signature _____

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THE PHYSICIANS FOUNDATION

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