THE ALPINE CLINIC, PLLC

A Division of Littleton Regional Health Care

REFERRAL REQUEST FORM

Please fax primary care referral to (603)823-8688

PRIMARY CARE PROVIDER: _____

PATIENT NAME: _____DOB:_____

PATIENT DIAGNOSIS: _____

The Alpine Clinic requires a PCP referral for all patients to be seen. We are honored to be the chosen specialist for your patients. We have found having complete medical history up front allows us to provide the best quality care to our mutual patients.

All referrals must include the following information: referral start and end date, as well as the number of authorized visits. *PLEASE NOTE: We cannot schedule a patient without the above information.*

Please return this completed form.
We do ask that any reports pertaining to the patient's prior medical history including; last office note, current medication list, nerve conduction or EMG studies, and a copy of the insurance card/s (front/back). This completed information will allow us to schedule patients promptly.

- Has the patient had any prior imaging done for this body part: ☐ YES ☐ NO
  IMAGING FACILITY: _____
- Has the patient had any prior surgeries to this body part: ☐ YES ☐ NO
  PLEASE NOTE: If yes, our providers will need to review all op notes prior to scheduling.

PLEASE CHOOSE PATIENT PREFERRED PROVIDER

Dr. Andrew L. Chen *Dr. Jeffrey I. Kauffman* *Dr. Dougald F. MacArthur* *Dr. Eric Mullins* *No Preference*

*START DATE: _____ *END DATE: _____ *AUTHORIZED NUMBER OF VISITS: _____

AUTHORIZATION NUMBER: _____ *(if applicable)*

*PCP SIGNATURE: _____

** Indicates required information for scheduling*

Please allow 48 hours before contacting our office to verify that primary care referral was received. If all information is included patients will be contacted for scheduling within 48 hours.

PHONE: (603)823-8600 **FAX:** (603)823-8688