PREMIER MEDICLINIC

Referral Form

I would like to refer my patient:_____

For:

- ☐ 1. Evaluation and Treatment
- ☐ 2. To be the Primary Care Physician
- ☐ 3. Medical Screening
- ☐ 4. Drug and Alcohol Testing
- ☐ 5. EKG
- ☐ 6. X-Rays
- ☐ 7. Laboratory
- ☐ 8. Disability Evaluation
- ☐ 9. Work Hardening
- ☐ 10. Work Conditioning
- ☐ 11. DOT Physicals
- ☐ 12. Physical Therapy and Rehabilitation
- ☐ 13. Functional Capacity Evaluation
- ☐ 14. Impairment Rating
- ☐ 15. Pain Management

Other significant medical problem:

_____

_____

Comments:

Referring signature:_____

Date:_____

Please Indicate Location:

Premier MediClinic

☐ 4101 S. Shary Rd. Suite 101-A Mission, Texas 78572

Phone: (956) 583-8889 • Fax: (956) 583-8820

☐ 801 East Nolana Suite 7 McAllen, Texas 78504

Phone: (956) 687-8120 • Fax:(956) 686-7793

www.PremierMediClinic.com