**www.AustinPodiatryHouseCalls.com**

 **by Dr. Joshel Brown**

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**info@AustinPodiatryHouseCalls.com**

**REFERRAL FORM**

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male?\_\_\_\_\_Female?\_\_\_\_

Street Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code+4:\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile Phone?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Typical Wake-up Time:\_\_\_\_\_\_\_\_\_\_

Date Of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Had Covid-19 Vaccine(s)?\_\_\_\_\_\_\_\_\_\_

Which Contact Method is Preferred? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drive a car?\_\_\_\_\_\_\_\_\_\_\_

Referring Source:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Source Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Dr**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\***DateLastSeen**:\_\_\_\_\_\_ *(Insurances require a Primary Dr’s exact visit date within 6 months.)*

**Primary Insurance Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gp#:\_\_\_\_\_\_\_\_\_\_\_\_ Primary Insurance Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gp#:\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Medicare Advantage plan? If so, that’s Primary.) Also, if able, please send card images, front and back (or have insurance cards at your appointment).***

**Medical Conditions & History**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications & Dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meds continued\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Food and Drug Allergies:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What foot conditions would you like treated?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History** (Medical conditions of your family members):*Father:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kids:\_\_\_\_\_\_\_\_\_\_*

**Social History:**

* Married?
* Smoker?
* Do you Exercise?
* Special Diet?
* Do you use any devices to walk? No\_\_\_\_ Walker\_\_\_\_ Cane\_\_\_\_ Wheelchair\_\_\_\_

**Surgical History**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity (optional):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language: English\_\_\_\_\_\_\_\_\_ Spanish \_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_

**Review of symptoms:** Please list any of your issues with the following body areas:

* Constitutional symptoms (fatigue, appetite & weight changes)
* Eyes (blurry vision, eye problems)
* Ears, nose, mouth, throat
* Cardiovascular
* Respiratory
* Gastrointestinal
* Genitourinary
* Musculoskeletal (joint pains, stiffness, arthritis)
* Integumentary (skin rashes, lesions, dryness)
* Neurological (numbness, burning, tingling)
* Psychiatric (anxiety, depression, memory loss)
* Endocrine (ex: thirst, sugar imbalances)
* Hematologic/Lymphatic (blood thinners, clotting issues)
* Allergic/Immunologic (hay fever, skin reactions, runny nose)