☐ **Pickup at Office**
☐ **Mail to Patient**
☐ **Mail to MD**

REFERRAL REQUEST FORM

This is a Yaffe, Ruden & Associates information sheet designed for internal office use **ONLY!** **This is a REQUEST for a referral, not a referral to be given to a specialist.** Please complete the form with as much information as you can and leave it in the basket on the referral counter or email completed form: **Letters A-M email: yralim@yafferuden.com Letters N-Z email: yralane@yafferuden.com. Thank you.**

* = **Required**

Today's Date*: _______________

Patient Name* (PLEASE PRINT) ______________________________________ ***D.O.B** ______________

Address: ____

City: ____________________________________ State: __________________ Zip: ______________

Day Phone*: (_____) __________________________ **Cell Phone*** (_____) ______________________

Primary Care Physician*: ☐ Bruce H. Yaffe M.D. ☐ Ronald A.Ruden M.D. ☐ Christine V. Kakoulas M.D
☐ Susan I. Rosen M.D. ☐ Deepa Shah-Barot D.O. ☐ Jared M. Braunstein D.O. ☐ Julie Bikhman, D.O.
☐ Kamila Seilhan, D.O. ☐ Shilpa Paradkar-Singh, M.D. ☐ Peggy-Rose Elango, D.O.

Examined By*: ____

Insurance Company: __________________________________ Plan Type **(on card):**________________

Insurance ID: __________________________________ Phone No. (_____) ______________________

Specialist*: ______________________________ **Specialty Type*:** ____________________________

Specialist Insurance Plan ID:____

Address: ____

City: __________________ State: ___________Zip: _________ Phone: (_____) ____________________

Reason to See Specialist*: ____

If suggesting diagnostic testing please specify test*: ____

Diagnosis*: ____________________________ **Symptoms:** ___________________________________

Condition to Rule Out*: ____

When ordering CT or MRI, please check one*: ☐ w/ Contrast ☐ w/o Contrast
Appointment Date: ______________________