



Fax Referral Form

★ Please include exam notes and demographics with referral ★

Pages attached: _____

Date: _____

Patient Name: _____ DOB: _____

Phone# Home: _____ Work: _____ Cell: _____

Reason for consultation/diagnosis: _____

How long have symptoms been occurring? _____

Schedule appointment: Today Within 2-3 days Within 1 week Next Available

Referring Physician: _____

Location: _____

Physician Phone: _____ Physician Fax: _____

Tri-Care Prime Patient? Authorization ***MUST*** be requested by Referring Doctor: Completed

Fax To: Colorado Springs office
2770 North Union Blvd., Suite 140
Colorado Springs, CO 80909

North Colorado Springs office
10035 Pearl Pass View, Suite 110
Colorado Springs, CO 80924

Pueblo office
3711 Parker Blvd.
Pueblo, CO 81008

Phone: (719) 473-9595 Fax: (719) 227-0669

Thank you for the referral!

RCSC OFFICE: _____

Initials: _____ Date: _____

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