



PHYSICIAN REFERRAL FORM

Referrals should include patient's (1) demographics, (2) most recent office note, and (3) current list of medications. All referrals can be faxed to **210.634.2652**, emailed to **referrals@cisofsa.com** or uploaded through our website at **https://www.cisofsa.com/referring**

PATIENT INFORMATION

REFERRAL DATE		PATIENT NAME			
ADDRESS				PHONE	
CITY	COUNTY	STATE		ZIP	
EMAIL		MALE / FEMALE	HEIGHT	WEIGHT	
PRIMARY CONTACT NAME		RELATIONSHIP		PHONE	
DRIVERS LICENSE/PERMIT #		STATE		EXP DATE	

MEDICAL HISTORY

DIAGNOSES

DATE OF ONSET	DX CODE(S)
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MOBILITY STATUS

(CHECK ALL THAT APPLY)

AMBULATORY
 CANE
 WALKER/ROLLATOR
 WHEELCHAIR:
 MANUAL
 POWER

OTHER _____

TRANSFER STATUS

ADDITIONAL NOTES

PHYSICIAN CONSENT

(CHECK ALL THAT APPLY)

COMPREHENSIVE DRIVING EVALUATION/TRAINING
I consent to my patient participating in a program to evaluate motor vehicle operation capacity

RETURN TO DRIVE/SENIOR SAFETY DRIVING EVALUATION/TRAINING
I consent to my patient undergoing a evaluation to determine driving fitness and participate in training if recommended following a major health event or change in medical status

<input type="checkbox"/> Please check if you would like to receive a copy of reports faxed to you	FAX
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PHYSICIAN SIGNATURE	DATE
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PHYSICIAN NAME (PRINT)	PHONE
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ADDRESS

*****PLEASE NOTE:** Signature/Date stamps are not acceptable. By signing this order you are acknowledging that you are an attending physician of this patient. This order expires 6 months from date signed.