Hong Truong, D.O, Hope Integrative Care Group NPI: 1518419167
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Phone: (781) 573-3977 Fax: (781) 573-3955

CONSULT REQUEST FORM

NAME OF PATIENT _____ **DOB** _____
DATE _____

REASON FOR REFERRAL?

Patient is in opioid /alcohol treatment with us started from _____.
Please grant _____ visits started from _____ to _____

PATIENT CONTACT INFORMATION
Address _____
City _____ State _____ Zip _____
Home # _____ Cell # (if applicable) _____

Primary Provider Name _____
Clinic Name_____Address _____
City_____ __State_____ Zip_____
Ph # ( )_____Fax # ( )_____ Email _____

PATIENT INSURANCE INFORMATION
Insurance: _____ Policyholder:_____
ID#: _____ Group #:_____ Employer:_____

****Referral Authorization #: _____**
**** # of Visits Authorized: _____**

FOR CLINIC USE ONLY
Referral form received (date/time):_____
Reviewed (date/time/init): _____ Accepted for Clinic: Yes No
Call back (date/time/init): _____