

Date: _____

Houk Chiropractic's Premier Wellness



CHIROPRACTIC CONSULTATION REQUEST FORM

Doctor Address and Phone:

Dr. Mark Houk
Chiropractic Orthopedist
Specialist Spinal Trauma

3809 N. Monroe
Spokane, WA 99205

Patient Address and Phone:

Dr. Kevin L. Henning
Chiropractic Neurologist

9720 N. Nevada
Spokane, WA 99218

Dr. Mark Ainslie
Chiropractic Physician

3809 N. Monroe
Spokane, WA 99205

Dear Doctor:

**Thank you for referring the above patient for a Chiropractic Consultation.
We will need the following items or copies sent one week prior to their
Scheduled examination:**

1. Please fill in the doctor and patient address and phone numbers above, as well as indicating by a check mark the doctor who will be performing the examination.
2. A Completed Consultation Referral Form. The consultation Referral form must be signed by the doctor and patient in the applicable spaces at the bottom.
3. Copy of initial accident information to include the History, Examination & Diagnosis.
4. Any other reports regarding this claim to include progress reports and Doctor Referral reports completed and/or received during the patient's care.
5. X-rays & their reports, obtained on this claim.
6. Copy of your daily chart notes.

A copy of my report as well as your x-rays will be sent to you approximately 14 days after scheduled examination. If you have any questions, please contact us at (509) 464-2273 or fax us at (509)242-1854 and ask for our office manager, Linda Depew.

We thank-you for your time in completing these forms.

Houk Chiropractic's Premier Wellness



Two Locations To Serve You!

9720 N. Nevada Spokane, WA 99218
Phone# (509)464-2273 Fax# (509)242-1854

3809 N. Monroe Spokane, WA 99205
Phone# (509)326-3795 Fax# (509)325-7418

Consultation Referral Form

Patient Name: _____

Date: _____

Claim #: _____ Please Check OPIP claim Third party claim L&I claim Other

D.O.I. ____/____/____

Date of First Visit: _____ Date of Last Visit: _____

Employer: _____ Insurance Company: _____

Adjustor Name: _____ Phone #: (____) _____ Ext. _____

Adjustor Address: _____

Consult Requested By: _____

Reason for Consult: _____

Accepted Condition / Diagnosis: _____

Care and Progress Provided To Date (overview of present condition and improvement): _____

Examination Scheduled for: _____

Please understand that time has been set aside for this examination and that failure to keep this appt without 48Hr notification may result in the claimant being responsible for payment.

Dr. Signature: _____ Patient Signature: _____