Nura Patient Referral Form

For Procedure Only Appointments
Fax Order, MRI and Patient Demographic Information to:
Fax: 763-767-7193
Email: dlpriorauth@nuraclinics.com

For Evaluation & Treatment Appointments
(Send along with records, radiology reports and 3-5 most recent office notes related to pain)
Fax: 763-537-6666
Email: Referral@nuraclinics.com

PROVIDER HOTLINE
If you have any questions about referring to Nura, call our **Provider Hotline: 763-537-1000,** 8 AM - 5 PM, M-F

PATIENT INFORMATION

Patient Name

_____ _____ **Date of Birth** *(MM/DD/YYYY)* _____
First *Last*

Patient Cell Phone _____ **Patient Alternative Phone** _____

Patient Email Address _____

REFERRING PROVIDER INFORMATION

Name of Referring Provider **Name of Referring Clinic**

_____ _____ _____
First *Last*

Clinic Phone _____ **Referring Provider Cell Phone** _____ **Fax** _____

Referring Provider Clinic Street Address

_____
Address *City/State/Zip*

Referring Provider Email Address

_____

❑ Evaluate and treat as necessary ❑ Ordered procedure *(indicate procedure to be performed below)* ❑ Other *(detail below)*

_____

_____

Follow up reports should be delivered: ❑ As needed ❑ Every visit ❑ Other _____

❑ **Send patient back to referring provider for:** *(e.g. physical therapy, medication management, etc.)*

_____

_____

Communicate plan of care back to me via: *(check appropriate box below)*

❑ Phone ❑ Fax ❑ Email

nura
Precision Pain Management

Main: 763-537-6000
For additional information visit **nuraclinics.com**

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