WESTERN MEDICINE, INC.
7774 Dayton - Springfield Rd
Fairborn,Oh 45324
937-864-7363ph 937-864-5895fax

REFERRAL REQUEST FORM

Referring Physician : _____ NPI # _____

Patient Name: _____ DOB: _____

Address: _____ Home Phone: _____ Cell # _____
_____ Work Phone: _____

Referring To: Sarah Rodewald, CNP Specialty: Family Medicine/Functional Medicine

Reason for Referral: Functional Medicine ICD-10 Code: _____

Patient's Insurance : _____ ID# _____

Referral Authorization or Certification # (if needed) _____

Please attach any recent labs and visit notes related to this condition.

Additional Information faxed with this request: _____ YES _____ NO _____ N/A

Person Completing this form: _____

Referring Physician Signature: _____ Date: _____