Lighthouse
FOOT & ANKLE CENTER, PC

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Phone: 207-774-0028/Fax: 207-774-0063
www.lighthousefootandankle.com

Patient Referral Form

Patient Information

First Name: ______________________________

Last Name: ______________________________

Address: ______________________________

Sex: ▪Male ▪Female Date of Birth: ______________

Ok to contact patient directly? ☐Yes ☐No

Patient Phone: ______________ E-mail: ______________________

- ❖ Please be advised our office is a direct care office. We do not participate with insurance.
- ❖ We can provide a superbill to the patient upon request.

Diagnosis or clinical information

Please check any that apply:

- ○ Foot/Ankle/Heel pain
- ○ Fungal Toenail
- ○ Neuroma
- ○ Neuropathy
- ○ Foot Care
- ○ Diabetic Foot care
- ○ Other ______________________

Additional information or comments:

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Referring Physician's Information

Physician Name: ______________________________

Office Name: ______________________________

Address: ______________________________

City, State, & Zip: ______________________________

Phone number: ______________________________

Fax number: ______________________________

E-mail: ______________________________

☐ Check here if e-mail is the preferred contact method