



**Fax Referral Form**

Fax To:

**517-659-5934**

Date of Referral: \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Name of person referred \_\_\_\_\_

Date of Birth \_\_\_\_\_ Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Reason for Referral:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Requests:

Upon receipt of this fax, therapy today staff will contact the patient and schedule an appointment with them. You will receive a fax confirmation of the appointment.

4572 S. Hagadorn Rd, Suite 1-C  
East Lansing, MI 48823  
(517)481-2133