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## Podiatry Referral Form

This form is electronic and will return to us on our secure server once completed, no need to fax. Demographics and records can be attached to this form as well. Please allow 24 hours for appointments to be scheduled.

Today's Date: \_\_\_\_\_ (MM/DD/YYYY)

Referring Provider/Facility: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance/ID: \_\_\_\_\_ Group \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Patient Email Address: \_\_\_\_\_

Indication/Diagnosis for Referral: \_\_\_\_\_

Bunions	Heel Pain/ Plantar or Achilles	Sports Injuries (Fractures, Sprains, Turf Toe)	Skin and Nails (Blister/Ingrown)	Other
Children's Foot care/Injury	Diabetic Foot Care (Charcot/Neuropathy/Wound)	Foot /Ankle Surgery	Custom Orthotics	Shockwave Therapy

Additional Comments: \_\_\_\_\_

Records/Labs Attached: \_\_\_Yes \_\_\_No

We appreciate your referrals! Thank you!

Richardson Podiatry, David Haddad DPM