NORTHERN ILLINOIS FOOT & ANKLE SPECIALISTS

PATIENT REFERRAL

Patient Name: _____

Patient Phone: _____ **DOB:** _____

Brief History: _____

- ☐ Achilles Tendonitis
- ☐ Ankle Instability
- ☐ Arthritis of Foot or Ankle
- ☐ Bunions
- ☐ Corns/Calluses
- ☐ Custom Orthotics/Bracing
- ☐ Diabetic Foot Care
- ☐ Flat Feet
- ☐ Gait Abnormalities
- ☐ Hammertoes/Clawtoes
- ☐ Heel Pain/ Plantar Fasciitis
- ☐ High Arches
- ☐ Infection
- ☐ Nail Conditions
- ☐ Nerve Pain/ Neuropathy
- ☐ Neuromas
- ☐ Pediatric Conditions
- ☐ Skin Conditions
- ☐ Sprains/Fractures
- ☐ Swelling
- ☐ Tendon Injuries
- ☐ Warts
- ☐ Wounds/Ulcers
- ☐ Other: _____

Physician Name: _____ **Company:** _____

Phone: _____ **Date:** _____

FAX COMPLETED FORM AND PATIENT FACE SHEET TO **815.526.3467**.
ONCE FAXED, PLEASE PROVIDE THIS FORM TO THE PATIENT TO SCHEDULE AN APPOINTMENT.

Find care at one of our convenient locations: IllinoisFoot.com/locations.

BOOK NOW

16 LOCATIONS ONE FOCUS

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