Referral to Foot and Ankle Clinics, P.A.

Jeffrey Pellersels, DPM

○ PATIENT WILL CALL TO SCHEDULE
○ PLEASE CALL PATIENT TO SCHEDULE

Preferred Location:

◉ 6545 France Ave S
Suite 565
Edina, MN 55435
952-934-9360

○ 563 Bielenberg Dr
Suite 150
Woodbury, MN 55125
651-457-3115

○ 1545 Livingston Ave
Suite 100
West St. Paul, MN 55118
651-457-4665

***PLEASE SEND COPIES OF RELEVANT CHART NOTES, X-RAYS OR ANY OTHER IMAGING STUDIES TO OUR OFFICE:

Fax: 651-457-3115
Email: information@footandankleclinics.com

PATIENT INFORMATION			
Name: LAST	FIRST	M.I.	**Sex:** Male ○ Female ○
Date of Birth	**Primary Care Physician (PCP):**		
Address:	**City**:	**State**:	**Zip Code**:
Primary Phone:	**Secondary Phone:**		
PRIMARY INSURANCE & SUBSCRIBER INFORMATION			
Primary Insurance Name:	**Relationship to Subscriber:**		
Subscriber's Name: LAST	FIRST	M.I.	**Subscriber's Date of Birth:**
Subscriber ID #	**Group #**	**Plan #**	
REFERRING PROVIDER INFORMATION			
Clinic Name:	**Provider/Physician Name:**		
Clinic Phone:	**Clinic Fax:**		
Clinic Email:	**Today's Date:**		
REASON FOR REFERRAL			
Symptoms / Indication / Diagnosis:			
Comments:			