



AZCLINICALTRIALS.COM

ACT PHOENIX – 480-360-4000 • ACT TUCSON – 520-445-4000

COVID-19 TREATMENT REFERRAL FORM

Preferred Office Location (check one): (patient can change site to be seen)

Mesa Office

2152 S Vineyard Ave Ste 123
Mesa, AZ 85210
Ph 480.360.4000
Fax 480.686.8875

Tucson Office

1601 N Swan Rd
Tucson, AZ 85712
Ph 520.445.4000
Fax 520.203.8226

Patient Name: _____

Patient Address: _____

DOB: ___/___/___ Gender: Male / Female Contact Email: _____

Contact Phone Number: (____)____-____ Alternative Number: (____)____-____

Best Time to Reach You:

Morning (8 - 11AM) Lunchtime (11AM - 1PM) Afternoon (1 - 5PM) Evening (After 5PM)

Name of Referring Provider: _____

Address: _____

Phone: (____)____-____ Fax: (____)____-____

How did you hear about us? (required): _____

****This is only a request to be considered for treatment and NOT A TRUE REFERRAL. Terms and conditions may apply. Not all referrals will qualify for treatment. Patients will be contacted to determine eligibility.**

Our guidelines are as follows:

Patients are contacted within (24-48) hours of receipt of the referral. If referral is marked STAT we will call them as soon as the referral is received.

Please advise patients their insurance will be charged but we cannot anticipate what a patient will be billed by their insurance.

Programs for coverage of uninsured may be available and discussed. Thank you.