Referral form

MidiHealth

REQUIRED INFORMATION – PLEASE WRITE CLEARLY

Patient Name _____ Patient Date of Birth _____

Patient Address (street, city, state, and zip) _____

Patient Insurance Name _____ Patient Cell Phone _____ Patient Email _____

* Currently, we cannot see Medicare or Medicaid patients

Patient Symptoms (mark all that apply)

- ☐ HOT FLASHES + NIGHT SWEATS
- ☐ BRAIN FOG + MEMORY LAPSES
- ☐ WEIGHT CHANGES
- ☐ TROUBLE SLEEPING
- ☐ PAINFUL SEX, VAGINAL DRYNESS + LIBIDO CHANGE
- ☐ BONE LOSS
- ☐ MOODINESS, ANXIETY + DEPRESSION
- ☐ HAIR + SKIN CHANGES
- ☐ PERIOD PROBLEMS
- ☐ MENOPAUSE AFTER CANCER
- ☐ MENOPAUSE WITH CANCER RISK
- ☐ OTHER: _____

Notes

_____

_____

Provider Name _____

Provider Fax Number _____ Provider Phone Number _____ Provider Email _____

How to refer a patient

Fax this form to **1–833–775–1861** or email this form to **referrals@joinmidi.com**.

What's next?

A Midi referral coordinator will reach out to your patient to schedule their first visit.

Questions? Call us at **1–888–731–8994**.