Bravo Health Presidio
602 W O Reilly St
Suite C
Presidio, TX 79845
P: (432) 289-6356 | F:(432) 239-5487

Referral Form

Referring to: Dr. Test Specialist
Referred from: RACHEL MENGES, MSN, APRN, FNP-BC

Patient Information:

Patient:3zzztest 3zzztest **DOB:** 01/01/1950 **Sex:** Male
Patient Address: 2450 Test St
Houston TX 77021
Patient Phone: (309)-945-7687
Patient Diagnosis:

Reason for Referral:
evaluate and treat for Anterior knee pain

Additional Referral Notes:

Insurance Information:
Trio Plan0000
Authorization #:
# of Visits:
Expiration Date:

MEMORIAL HERMANN
OnSite Clinic
IN ASSOCIATION WITH Hamilton Health Box

HAMILTON HEALTHBOX

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

Patient Demographics

Patient Name: 3zzztest 3zzztest
Date of Birth: 01/01/1950
Gender: Male
Preferred Language: English
Bill Type: INSURANCE
Primary Insurance: Trio Plan

Date and Location of Visit

Date of Service: 12/08/2025
Chart Number: HHB2A7
Location: HHRTRM
Appointment: 12/08/2025 10:45 AM CST
Appt. Reason: ESTABLISHED PATIENT
Notes:

Medication Summary

Drug Allergies
amoxicillin (amoxicillin) rash (Active)
peanut oil (peanut oil) urticaria (hives) (Active)
ibuprofen (ibuprofen) Lip swelling (Active)

Current Medications
Tylenol (acetaminophen) tablet 325 mg

Medication Reconciliation:
Not performed

Subjective

Medical History
Past Medical History: ☐**None**

☐ADHD	☐COPD	☐Irritable Bowels	☐Prostate Problems	☐Urinary Tract Infection
☐Seasonal Allergies	☐ Depression	☐Irregular Heartbeat	☐Psychiatric Problems	☐Cancer
☐Amputation	☐Dementia	☐Incontinence	☐Rheumatoid Arthritis	☐
☐Anemia	☐Diabetes	☐Kidney Disorder	☐Seizures	☐
☐Anxiety	☐Gastrointestinal Disorder(s)	☐Kidney Stone	☐ Sinus Issues	☐
☑Asthma	☐GERD	☐Lung Disorder(s)	☑Skin Problems	☐
☐Autoimmune Disorder(s)	☐Glaucoma	☐Memory Impairment	☐Sleep Apnea	☐
☐Blood Clot	☐Heart Condition	☐Migraine Headaches	☐STI	☐
☐Blood Disorder(s)	☐Hepatitis	☐Neuropathy	☐Stroke	☐
☐Cataract	☐Hypertension	☐Osteoarthritis	☐Thyroid Disorder	☐
☐Cirrhosis	☐Hypotension	☐OB-GYN Problems	☐Tuberculosis	☐
☐Crohn's Disease	☐High Cholesterol	☐Pneumonia	☐Ulcer	☐

FAMILY MEDICAL HISTORY ☐ family history unknown

Mother	☑Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Father	☐Hypertension ☑Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Siblings	☑Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)
Family (Other)	☐Hypertension ☐Diabetes ☐Stroke ☐Heart Disease/Heart Attack ☐High Cholesterol ☐Thyroid Disease ☐Cancer (Type)

Social History:
Occupation: ☐Retired ☐Disabled ☐Student ☐Homemaker ☐Unemployed ☐Self-Employed ☑Employed Full-Time ☐Employed Part-Time
Marital Status: ☐Single ☐Married ☑Divorced ☐Widow/Widower ☐Domestic Partner ☐ In a long-term relationship
Number of Children: 2 Do you live alone: ☑Yes ☐No
Alcohol: ☐Yes ☑No Amount: **2** ☑Social Drinker ☐NON DRINKER
Substance Abuse: ☐Yes ☑No Type:
Do you exercise regularly? ☑ Yes ☐No **If yes, what type and how often?
Special Diet? none
Are you a smoker? ☐Yes ☐No Have you ever been a smoker? ☐ Yes ☐ No
If yes, Age Started Smoking Age Stopped PPD
Are you an E-Cigarette User ☐Yes ☐No` Do you use smokeless tobacco? ☐Yes ☐No

SURGICAL HISTORY ☐ No surgical history

☑ Appendectomy	☐ Cesarean	☐ Breast Biopsy	☐ CABG	☐Cataracts
☐ Cholecystectomy	☐ EGD	☐Mastectomy ☐Lumpectomy	☐ Cardiac Cath	☐Thyroidectomy
☐ Hysterectomy	☐ Circumcision	☐ Knee Surgery	☐Pacemaker/Defibrillator	☐Splenectomy
☐ Tubal Ligation	☐ Hernia Repair	☐Hip Surgery	☐ Ear Tubes	☐ Carotid Endarterectomy
☐ D&C	☐ Bladder Surgery	☐ Back Surgery	☐ Tonsils/Adenoids	☐ Other

What Kind?	Where was it done?	When?

Specialists: ☑**None**

Specialty	Frequency	Last Visit	Next Visit	Comment/Reason

Hospitalizations or Other Medical Problems: ☑**None**

Why?	Where?	When?

HEALTH MAINTENANCE

☑Colonoscopy ☐ COLOGUARD ☐FOBT (Date): 1/1/2020	☐Chest XRAY (Date):
☐Screening Mammogram (Date):	☐Low dose CT chest (lung cancer screening) (Date):
☐ PAP smear (Date):	☐ Eye Exam (Date):
☐DEXA scan (Date):	☐ TB skin test (Date):

Immunization History (LIST DATES IF KNOWN)

Tdap ☐	Prevnar 13☐	Pneumovax 23☐	COVID 19 ☐	Influenza ☐	Shingles ☐

Other Immunization History:
Flu: Date:
Other:

Gynecology History- Women only:
Date of last menstrual period: Menopause? Currently Pregnant?
G: P: M: A:
Method of Contraceptive:
Date of last Pap Smear: Where?
Date of last Mammogram: Where?

Immunization History:
Pneumonia Vaccination: Date: ; Date:
Shingrix Vaccination: 1st: 2nd:
TD: Date:
Flu: Date:
Other:

End of Life Plan:
Advanced Directives?
Living Will?
Medical Power of Attorney? Name: Relationship:
DNR? Filed Where?

Smoking Status

Status:	Never smoker
Effective Date:	12/08/2025
Snomed code:	266919005

Problem History

C.S.	Code	Description	Status	Diagnosed	Edu.	Cog.	Func.	Diagnosed By	Resolved By
ICD10	M25.561	Pain in right knee	ACTIVE	12/08/2025 04:06 PM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	R05.3	Chronic cough	ACTIVE	12/02/2025 12:00 AM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	E11.9	Type 2 diabetes mellitus without complications	ACTIVE	11/19/2025 12:00 AM CST	Yes	No	No	DANIELLE OLSZESKI	N/A
ICD10	F32.1	Major depressive disorder, single episode, moderate	ACTIVE	11/18/2025 03:16 PM CST	Yes	No	No	DANIELLE OLSZESKI	N/A
ICD10	E11.39	Type 2 diabetes w oth diabetic ophthalmic complication	ACTIVE	11/18/2025 03:11 PM CST	Yes	No	No	DANIELLE OLSZESKI	N/A
ICD10	E78.5	Hyperlipidemia, unspecified	ACTIVE	11/18/2025 03:09 PM CST	No	No	No	DANIELLE OLSZESKI	N/A
ICD10	I10	Essential (primary) hypertension	ACTIVE	11/17/2025 02:08 PM CST	No	No	No	DANIELLE OLSZESKI	N/A

Assessment

Diagnosis Codes

C.S.	Code	Description	Status	Diagnosed	Education	Cog.	Func.
ICD10	M25.561	Pain in right knee	ACTIVE	12/08/2025	No	No	No

Plan

Patient Referred Out and Summary of Care Provided: No
Clinical Summary Provided: No

Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST

*Please make the necessary corrections below

Name: 3ZZZTEST, 3ZZZTEST	HAMILTON HEALTH BOX CENTRAL	Phone: (832) 841-4269
PID: HHB2	2450 HOLCOMBE BLVD STE 2200, SUITE 2200	Fax: (832) 376-7445
MRN:	HOUSTON, TX 77021	Hours: 8:00 am - 5:00 pm

X-Ray#:
Gender: MALE
DOB: 01/01/1950 (76 y.o.)
SSN:
Email: danielle.olszeski@hamilton
Pri. Phone: (309)945-7687
Work Phone:
Cell Phone:
Address: 2450 TEST ST
HOUSTON, TX 77021

Emergency Name: XXXTEST XXXTEST
Emergency#: (555)555-5555
Occupation:
Employment Status:
Employer Name:
Employer Address:

*** Please notify staff of any changes below ***
Medication Updates: Yes / No
Allergy Updates: Yes / No
Primary Physician: _____

Guarantor Name:
Patient's Relationship to Guarantor:
Address:

DOB:
SSN: XXX-XX-
Pri. Phone: ()-
Work Phone: ()-
Employer:

Patient Insurances

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
Name: Trio Plan Address: 11421 TODD ST HOUSTON, TX 77055 Policy #: 0000 Group #: Copay #: Patient-Relationship: SELF Insured Name: 3ZZZTEST, 3ZZZTEST Insured DOB: 01/01/1950 Insured SSN: Insured Gender: MALE	XXX-XX-	XXX-XX-

Update of Information - Please update all fields inconsistant with our records above

Patient	Guarantor	Additional Notes
Pri. Phone: ( ) -	( ) -	
Work Phone: ( ) -	( ) -	
Cell Phone: ( ) -	( ) -	
Address:		
Employer:		
Other:		

By signing below, I acknowledge that the above demographic information is correct and that I have made any corrections or changes as appropriate. I understand that I may be liable for charges that result from any inaccurate information provided.

Signature: _____ Date: _____