Bravo Health Marfa
105 E Oak St
Marfa, TX 79843
P: (432) 729-3000 | F:(432) 729-3001

Referral Form

Referring to: Dr. John Smith
Referred from: DANIELLE OLSZESKI, PA

Patient Information:

Patient: 111test 111santos **DOB:** 01/30/1987 **Sex:** Female
Patient Address: 123 Greens Houston TX 77060 **Patient Phone:** 1-(234)-567-891
Patient Diagnosis:

Reason for Referral:
evaluate and treat for Refer to Dr. Simpson Rheumatology Boris Kaim (NPI: 1326054164)

Frontier Neurology
2311 N Mesa St Building F
El Paso, TX 79902

Phone: 9155446400
Fax: 9155442836

Additional Referral Notes:

Insurance Information:
Vtg Non Hdhp12354567
Authorization #:
# of Visits:
Expiration Date:

MEMORIAL HERMANN
OnSite Clinic
IN ASSOCIATION WITH Hamilton Health Box

HAMILTON HEALTHBOX

Previously Electronically Signed by: DANIELLE OLSZESKI on 01/02/2026 04:10 PM CST
Waiting for reviewer signature.

Patient Demographics

Patient Name:	111test 111santos		
Date of Birth:	01/30/1987		
Gender:	Female		
Preferred Language:	English	**Bill Type:**	SELF PAY (PATIENT)

Care Team

Rendering Provider: DANIELLE OLSZESKI, PA

Date and Location of Visit

Date of Service:	12/23/2025	**Appointment:**	12/23/2025 09:00 AM CST
Chart Number:	HHB6A4	**Appt. Reason:**	ESTABLISHED PATIENT
Location:	HHBTBM	**Notes:**	cough x3 days

Medication Summary

Drug Allergies
No Known Drug Allergies

Medication Reconciliation:
Relevant and performed

Chief Complaint / Assistant Note

Pt 111test, a 38 y.o.Female, presents with .

Subjective

HPI

What brings you in today?
→ "What&#39s going on?" or "What are you being seen for today?"

When did it start?
→ Days, weeks, etc.

Where is it located?
→ Be specific: "left knee," "lower back," etc.

What does it feel like?
→ Sharp, dull, pressure, itchy, etc.

Has it gotten better, worse, or stayed the same?

Any other symptoms?
→ Fever, nausea, cough, swelling, etc.

Have you done anything to treat it so far?
→ Medications, ice/heat, rest, ER/urgent care, home remedies

Medical History- Adult
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: Do you live alone: ☐Yes ☐No
Alcohol: ☐Yes ☐No Amount: ☐Social Drinker ☐NON DRINKER
Substance Abuse: ☐Yes ☐No Type:
Do you exercise regularly? ☐ Yes ☐No **If yes, what type and how often?
Special Diet?
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

Sexually Active

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):	☐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):

Gynecology History- Women only:
☐n/a
Date of last menstrual period: Menopause? Currently Pregnant? . Breastfeeding
G: P: M: A:
Method of Contraceptive:

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?

ROS

REVIEW OF SYSTEMS

SYSTEMS	WNL	ABNORMAL
GENERAL	☐	☐WEIGHT CHANGE ☐FATIGUE ☐FEVER ☐CHILLS ☐NIGHT SWEATS ☐DECREASED ENERGY LEVEL ☐RECENT ILLNESS ☐WEAKNESS ☐INSOMNIA ☐SWEATING ☐NOCTURNAL COUGH
SKIN	☐	☐DELAYED HEALING ☐RASH ☐BRUISING ☐BLEEDING ☐SKIN DISCOLORATION ☐CHANGE IN SKIN LESION/MOLE ☐LUMP ☐BUMP ☐SKIN LESION ☐SORE ☐INSECT BITE
HEAD	☐	☐ HEADACHES ☐ITCHY SCALP ☐ RECENT HEADINJURY ☐ CONCUSSION
EYES	☐	☐BLURRED VISION ☐CHANGE IN VISION ☐DISCHARGE ☐EYE PAIN ☐PHOTOPHOBIA ☐EYE REDNESS
EARS	☐	☐EAR PAIN ☐HEARING LOSS ☐RINGING IN EAR ☐DISCHARGE ☐HEARING AID
NOSE/MOUTH/THROAT	☐	☐SINUS CONGESTION ☐DYSPHAGIA ☐NOSE BLEED ☐NASAL DISCHARGE ☐DENTAL PAIN ☐HOARSENESS ☐SORE TI IROAT
BREAST ☐N/A	☐	☐LUMPS ☐BUMPS ☐CHANGES
HEME/LYMPH/ENDO	☐	☐HIV ☐BRUISING ☐HX OF BLOOD TRANSFUSION ☐NIGHT SWEATS ☐SWOLLEN GLANDS ☐INCREASE THIRST ☐INCREASE HUNGER ☐COLD INTOLERANCE ☐HEAT INTOLERANCE ☐ABNORMAL BLEEDING
CARDIOVASCULAR	☐	☐CHEST PAIN ☐PALPITATIONS ☐PND ☐ORTHOPNEA ☐EDEMA ☐SWEATING WITH FEEDING ☐EXERCISE INTOLERANCE
RESPIRATORY	☐	☐COUGH ☐WHEEZING ☐HEMOPTYSIS ☐DYSPNEA ☐PNEUMONIA HX ☐TB ☐ASTHMA HX ☐PRODUCTIVE SPUTUM ☐HOME OXYGEN @LPM.
GASTROINTESTINAL	☐	☐NAUSEA ☐VOMITING ☐DIARRHEA ☐CONSTIPATION ☐HEPATITIS ☐HEMORRHOIDS ☐EATING DISORDER ☐ULCER ☐BLACK TARRY STOOL ☐ABDOMINAL PAIN ☐BLOOD IN STOOL ☐GERD ☐HEARTBURN
GENITOURINARY/NEPHROLOGY	☐	☐URGENCY ☐FREQUENCY ☐BURNING ☐DYSURIA ☐CHANGE IN COLOR OF URINE ☐INCONTINENCE ☐DISCHARGE ☐BLOOD IN URINE ☐PAINFUL/SWOLLEN GENITAL AREA
GYNECOLOGICAL ☐N/A LNMP	☐	
MUSCULOSKELETAL	☐	☐BACK PAIN ☐JOINT SWELLING ☐STIFFNESS ☐JOINT PAIN ☐FRACTURE HX ☐OSTEOPOROSIS ☐MUSCLE WEAKNESS ☐MYALGIA ☐FREQUENT FALLS ☐NECK PAIN ☐BACK PAIN
NEUROLOGICAL	☐	☐SYNCOPE ☐SEIZURES ☐TRANSIENT PARALYSIS ☐WEAKNESS ☐PARESTHESIA ☐BLACK OUT SPELLS ☐SENSORY CHANGE ☐TINGLING☐DIZZINESS ☐SPEECH CHANGE ☐HEADACHE ☐TREMORS ☐DIFFICULTY/TROUBLE SWALLOWING
PSYCHIATRIC	☐	☐DEPRESSION ☐ANXIETY ☐NERVOUS ☐SLEEPING DIFFICULTY ☐SUBSTANCE ABUSE ☐SUICIDAL IDEATIONS/ATTEMPTS ☐PREVIOUS DX ☐INSOMNIA ☐HALLUCINATIONS ☐DISTURBED SLEEP
ENDOCRINE	☐	☐INCREASE THIRST ☐INCREASE URINATION ☐HIGH BLOOD SUGAR ☐LOW BLOOD SUGAR
ADDITIONAL COMMENTS :		

PHQ-2

Little interest or pleasure in doing things in last 2 weeks	Select...
Feeling down, depressed, or hopeless in last 2 weeks	Select...
Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]	0

Objective

Vitals

Head Circum (in)	Height/Length	Weight	BMI	Blood Pressure (mm/Hg)	Temp	Pulse	Inhaled O2	Inhaled O2 Flow Rate	Notes	Timestamp

120/80 (SITTING)

FALAQ GAITHER
Completed:
12/23/2025 08:42:00 AM CST

Objective Notes

Assessment

Assessment Notes

Procedure

Procedure Notes

Plan

Plan Notes

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

Referrals

Provider	Specialty	Description / Reason	DX Pointers
	None	(Code:) Refer to Dr. Simpson Rheumatology Boris Kaim (NPI: 1326054164) Frontier Neurology 2311 N Mesa St Building F El Paso, TX 79902 Phone: 9155446400 Fax: 9155442836	

Additional SOAP Comments

*Please make the necessary corrections below

Name: 111SANTOS , 111TEST	HAMILTON HEALTH BOX CENTRAL	Phone: (832) 841-4269
PID: HHB6	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: FEMALE
DOB: 01/30/1987 (38 y.o.)
SSN:
Email:
Pri. Phone: (123)456-7891
Work Phone:
Cell Phone:
Address: 123 GREENS
HOUSTON, TX 77060

Emergency Name: TEST,JESSICA
Emergency#: (123)456-1479
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: 111SANTOS , 111TEST
Patient's Relationship to Guarantor: SELF
Address: 123 GREENS
HOUSTON, TX 77060

DOB: 01/30/1987
SSN: XXX-XX-
Pri. Phone: (123)456-7891
Work Phone: ()-
Employer:

Patient Insurances

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY INSURANCE
Name: VTG non HDHP	Arena non HDHP	
Address: 5851 SAN FELIPE ST UNIT 225 HOUSTON, TX 77057	2103 RESEARCH FOREST DR STE 246 SUITE 246 SPRING, TX 77380	
Policy #: 12354567	0000	
Group #:		
Copay #:		
Patient-Relationship: SELF	SELF	
Insured Name: 111SANTOS , 111TEST	111SANTOS , 111TEST	
Insured DOB: 01/30/1987	01/30/1987	
Insured SSN:	XXX-XX-	XXX-XX-
Insured Gender: FEMALE	FEMALE	

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: _____