Physician Referral Form

Phone 205-345-0192
Fax 205-345-3374

Scheduling Information:

Patient Name: ____ DOB: ___________________Sex: ____M____ F

Guardian's Name (if minor)____

Address:____City______________________State_____Zip____________

Home #: (_____)_____________________ Work #: (_____)_____________________ Cell #: (_____)_________________________

Signs/Symptoms:____

____

Has the patient seen another orthopaedist for this problem? ____Yes _____No

Previous Films within the last year: _____X-Ray _____MRI _____CT _____Other_____________________________________

Area of Body Requiring Assessment:

Left	Right	Description	Left	Right	Description	Left	Right	Description
		Hip			Elbow			Thoracic Spine
		Knee			Wrist/Hand			Lumbar Spine
		Shoulder			Cervical Spine			Ankle/Foot

Special Instructions:

Physician Preference ___________________________________Location Preference __________________________________

_____Call patient to schedule _____Patient will call to schedule ___ Other____

Time frame for appointment: _____Today _____First Available

Insurance Information:

Insurance Information (Please include a front and back copy of all insurance cards)

Insurance Name_______________________________________Plan #_________________________Group#___________________

Authorization Required? ___Yes___ No If Yes, authorization number____

____ Work Comp or ____ Auto:____ Date of Injury:_________________

Referral Office Information

Referring Group:____

Referring Physician:____ Phone: ______________________________

Contact Person:____Email:_________________________________

Notes:____