

MIDLANDS ORTHOPAEDICS, P.A.

-----Pediatric Patient Referral Fax Form-----



ATTN: Appointment Scheduling Department FAX: (803)-254-2825*

PATIENT'S NAME _____ TODAY'S DATE _____

GUARDIAN'S NAME (IF MINOR) _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX MALE FEMALE DATE OF BIRTH _____

PHONE (HOME) _____ (WORK) _____

PATIENT'S SOCIAL SECURITY NUMBER _____

INSURANCE _____

(Please include a front and back copy of all insurance cards. If insurance is Medicaid, please include patient's Medicaid number above. If the patient's insurance requires a referral, please fax to the number at the top of this page as soon as possible.)

HAS THE PATIENT SEEN ANOTHER ORTHOPAEDIST FOR THIS PROBLEM? YES NO

HAVE XRAYS BEEN TAKEN FOR THIS PROBLEM? YES NO

REFERRING PHYSICIAN _____

REFERRING PHYSICIAN CONTACT NAME _____

PHONE _____ (ext) _____ FAX _____

REASON FOR REFERRAL (List body parts(s) effected and the problem) _____

REFERRING PHYSICIAN REQUESTING CONSULT? _____ YES _____ NO

TIME FRAME FOR APPOINTMENT TODAY FIRST AVAILABLE

LOCATION _____

PHYSICIAN REQUESTED

Dr. Fred Piehl Stephanie Schaller, NP Other MOPA Physician _____