

# MIDLANDS ORTHOPAEDICS, P.A.

## Patient Referral Fax Form



### Appointments 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

(If YES, Patient must bring x-rays to their appointment)

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

- Robert M. Peele, Jr., M.D.
- Michael R. Ugino, M.D.
- Michael S. Green, M.D.
- M. David Redmond, M.D.
- Robert M. DaSilva, M.D.

- Frederick C. Piehl, M.D.
- Thomas P. Gross, M.D.
- James A. O'Leary, M.D.
- Coleman D. Fowble, M.D.
- William C. James, III, M.D.

- Thomas D. Armsey, II, M.D.
- Bernie G. Kirol
- Ivan E. LaMotta