

MIDLANDS
orthopaedics, p.a.

WORKERS' COMP PATIENT REFERRAL
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For office use only:
Date: _____ Chart # _____ Physician: _____ Initials: _____
Appointment Date: _____ Appointment Time: _____ Office Location: _____

ALL INFORMATION MUST BE OBTAINED PRIOR TO MAKING APPOINTMENT

Patient Name: _____ Daytime Phone # _____
Patient Address: _____ City/St/Zip: _____
Patient SS #: _____ Patient DOB _____
Date of Injury _____ Body Part / Side _____
How Injury Occurred: _____

Employer at Time of Injury: _____ Phone # _____
Employer Address: _____ City/St/Zip: _____
Workers' Comp Carrier: _____
Carrier Address: _____ City/St/Zip: _____
Adjuster/Case Manager Name: _____ Claim #: _____
Adjuster Phone #: _____ Adjuster Fax #: _____
Workers' Comp Verified and Approved by: _____ Relationship to Pt: _____

Referring Physician: _____ Referring Physician Contact: _____

Referring Physician Phone #: _____ Fax #: _____

Have x-rays been taken since this injury occurred? Yes No (If yes, films must accompany patient to appt)

Has treatment been rendered for this injury? Yes No (If yes, records must accompany patient to appt)

Comments: _____

