UNIVERSITY ORTHOPAEDIC CLINIC

ORTHOPAEDIC • SPINE • SPORTS MEDICINE

PHYSICIAN REFERRAL FORM

Scheduling Information:

Patient Name: _____ DOB: _____ SEX: _____ M _____ F

Guardian's Name (If Minor): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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 _____

Timeframe 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: _____

Fax Completed Form to 205-759-8789

REV: 02/24/2021