CULLMAN REGIONAL | Medical Group

*Orthopedics & Sports Medicine*
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# ORTHOPEDIC SURGEON REFERRAL FORM

Patient Name: _____

DOB: _____ Phone #: _____ Cell #: _____

Height: _____ Weight: _____

Address: _____

_____

Insurance Carrier: _____

Policy #: _____

***Referral authorization # if required*** _____

***Please include clinical documentation such as imaging, lab work, clinic notes, if available.***

## TESTS REQUESTED (CIRCLE ONE)

X-ray MRI Bone Density CT

## BODY PART INVOLVED (CIRCLE)

| | | | |
|---|---|---|---|
| Shoulder | Knee | Arm | Ankle |
| Elbow | Foot | Finger | Toe |
| Hand | Wrist | Hip | Pelvis |

Other: _____ Allergies: _____

## PRIMARY COMPLAINT (CIRCLE)

Pain Injury _____ Swelling Numbness Weakness

Other: _____ Allergies: _____

## ORDERING PROVIDER

Physician: _____

Phone #: _____ Fax #: _____

**Provider Signature:** _____

Appointment Date/Time: _____ Patient notified on: _____

*Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures*