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