Orthopedics & Sports Medicine
Vincent Bergquist, MD • Stephen Gould, MD
Don Hirsbrunner, MD
1938 Alabama Hwy 157, Suite 101, Cullman, AL 35058
(256) 735-5505 **FAX: (256) 964-9954**

ORTHOPEDIC SURGEON REFERRAL FORM

Patient's 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 #: ____________

Physician Signature: ____________

Appointment Date/Time: ____________ Patient notified on: ____________

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

Phone: (256) 735-5505 Fax: (256) 964-9954

Revised 10/2021