CULLMAN REGIONAL | Medical Group

Robert Ocampo, DPM
1938 Alabama Highway 157, Suite 101
Cullman, AL 35058
(256) 735-5505 **FAX: (256) 964-9954**

PODIATRY 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)

Ankle Foot Toe ☐ Left ☐ Right

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

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