PHYSICIAN REFERRAL/CONSULT FORM

Referral/Consult phone number: **256-351-8022** Fax: **256-355-9779**

Referring Physician

Physician Name: _____ Phone: _____

Office Contact: _____ Fax: _____

DOC Surgeons

☐ FIRST AVAILABLE

☐ **J. Randall Riehl, M.D.**

☐ **R. Scott Sharp, M.D.**

☐ **R. Stacy Tapscott, M.D.**

☐ **Justin L. Daigre, M.D.**

☐ **Justin D. Hallock, M.D.**

Physical Medicine & Rehabilitation

Russell Ellis, M.D

☐ Epidural Steroid Injection (**ESI**)

☐ NCS/EMG

☐ Left Upper Extremity ☐ Right Upper Extremity

☐ Left Lower Extremity ☐ Right Lower Extremity

Preferred Location

☐ Decatur ☐ Hartselle

Patient Information

Patient Name: _____ DOB: _____

Cell Phone: _____ Alternate Phone: _____

Reason for referral: _____

Insurance Name: ☐ BCBS ☐ Medicare ☐ Medicaid ☐ UHC Other: _____

Policy#: _____ Group #: _____

☐ Worker's Comp - Employer: _____

Does the patient have ☐ X-rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve conduction studies ☐ US

If **YES**, Location Performed: _____

(Please have patient bring them to their appointment)

Appointment Date & Time

Requested day of the week: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri AM

Requested time of day: ☐ AM Clinic ☐ PM Clinic

FOR OFFICE USE ONLY

Scheduled

Date: _____

Time: _____

Please send all records and radiology reports pertaining to diagnosis with faxed referral