DOC ORTHOPAEDICS & sports medicine

# 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.

## Physical Medicine & Rehabilitation

☐ Russell Ellis, M.D

☐ Epidural Steroid Injection (ESI)

☐ NCS/EMG _____

☐ Right Upper Extremity ☐ Right Lower Extremity

☐ Left Lower Extremity ☐ Left Upper Extremity

## Preferred Location

☐ Decatur ☐ Hartselle

## Advanced Practitioner Provider

☐ Olivia Walsh, P.A.

☐ Spine – Non surgical

## 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