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: ______________________

Preferred Location ☐ Decatur ☐ Hartselle

DOC Providers

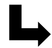
☐ **First Available** (any provider)

☐ **J. Randall Riehl, M.D.**	☐ **R. Stacy Tapscott, M.D.**
☐ **R. Scott Sharp, M.D.**	☐ **Justin L. Daigre, M.D.**
☐ **Russell L. Ellis, M.D**	☐ **Justin D. Hallock, M.D.**

Services

☐ Epidural Steroid Injection (**ESI**)

☐ NCS/EMG

 ☐ Left Upper Extremity ☐ Right Upper Extremity ☐ Left Lower Extremity ☐ Right Lower Extremity

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)

FOR OFFICE USE ONLY

Scheduled

Date: ____________________

Time: ____________________

Appointment Date & Time

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

Requested time of day: ☐ AM Clinic ☐ PM Clinic

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