DOC ORTHOPAEDICS & sports medicine

PHYSICIAN REFERRAL/CONSULT FORM

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

Referring 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.**	☐ **Matthew Nalamlieng, D.P.M.**
☐ **R. Scott Sharp, M.D**	☐ **Justin L. Daigre, M.D.**	
☐ **Russell 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

☐ Osteoporosis Evaluation - **Rebecca Stephenson, CRNP**

Patient Information

Patient Name: _____ DOB: _____ Cell 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 disk with 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