BONE & JOINT

Please FAX to 715.393.0390 Today's Date: _____

Physician Referral and Consult – New Patient/New Problem Referral Form

Patient's Last Name: _____ First Name: _____ M.I.: _____

Patient DOB: _____ Home Phone: _____ Cell Phone: _____

Can we leave a voice message on above phone numbers: ☐ Yes ☐ No

Address: _____ City: _____ Zip: _____

Primary Insurance: _____ Secondary Insurance: _____

Referring Clinic Name:_____

Referring Physician: _____ Phone: _____ Fax: _____

Reason for Referral/Body Part: _____

Is this Work Comp Related: ☐ Yes ☐ No Has the patient seen a Physician Level Provider yet? ☐ Yes ☐ No

Date of Injury: _____ Employer: _____ Phone: _____

WC Insurance: _____ WC Claim #: _____

WC Adjuster: _____ Phone: _____ Fax: _____

How soon does the patient need to be seen? ☐ ASAP ☐ 1-2 weeks ☐ 2-4 weeks ☐ Other: _____

Bone and Joint Preferred Location: ☐ Wausau ☐ Plover ☐ Merrill ☐ Medford

Provider Preference Level: ☐ Physician ☐ APP/Mid-Level Specific Provider: _____

Who should we contact to schedule the appointment? ☐ Your (referring) Clinic ☐ Patient

Please indicate if any of the following has occurred?						
	Yes	No	Date	Physician's Name	Clinic/Hospital Location	City/State
X-rays/MRI						
Physical therapy/ Chiropractor						
Previous Surgery/ Injections						
Previous Care with any Provider						

Appointment Date: _____ Provider: _____ Location: ☐ Wausau ☐ Plover ☐ Merrill ☐ Medford

Insurance: _____ NP Packet Sent to Patient? ☐ Yes ☐ No Staff Initials: _____