OrthoGeorgia Appointment Request Form

MACON/MILLEDGVILLE/DUBLIN

Phone (478) 745-4206

Fax (478) 741-9657

WARNER ROBINS/KATHLEEN

Phone (478) 971-1153

Fax (478) 971-1174

Date:___________________________ Referring Physician:____

Phone:___________________________________ Fax:____

Contact Name:____

Patient's Name____

DOB:____ SSN:____

Mailing Address:____

City, State, Zip:____

Home Phone:_______________________________________ Cell:____

Work Number:_____________________________________Email:____

Requesting Consult For:____

Physician Requested:______________________________________ OR _____________ First Available

Location Requested: ________ MACON ______ WARNER ROBINS ______ KATHLEEN _______ MILLEDGEVILLE

________GRIFFIN _________ DUBLIN

Has the patient had any previous surgery on the body part being referred? ______YES _____NO

If yes, name, location of surgeon, and date of surgery (please attach records for review):

____

Has patient seen OrthoGeorgia physician before? _____YES _____ NO If yes, name________________________

Is this related to a: Work Injury? ______ YES _____ NO MVA? ______YES _______ NO

If work related injury: Adjuster's Name__________________________________ Phone______________________

Primary Insurance:___________________________________ Policy #_______________________________________

Secondary Insurance:________________________________ Policy #_______________________________________

*** Authorization must accompany referral for all TRICARE Prime, HMO and Affordable Care Act Plans.

*** Please remember to include: demographics, with a copy of all insurance cards, physician's notes and any X-Ray, MRI, CT Scans, or EMG/NCV results

***Patients must bring all films (film or disk) to their appointment.

Thank you for your referral! Please contact us with questions or if we may assist in any way.