



OrthoGeorgia Appointment Request Form

MACON/MILLEDGEVILLE/DUBLIN

WARNER ROBINS/KATHLEEN/HAWKINSVILLE

Phone (478) 745-4206

Phone (478) 971-1153

Fax (478) 741-9657

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 _____ HAWKINSVILLE _____ 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.
