Rev 1/27/2016

BONE & JOINT

Please FAX to 715.393.0390

Physician Referral and Consult FAX Line

New Patient/New Problem Referral Form

Today's Date: _____ Referring Clinic Name: _____

Patient Last Name: _____ First Name: _____ M.I.: _____
Patient DOB: _____

Address: _____ City: _____ ZIP: _____

Home Phone: _____
Can we leave a message? ☐ Yes ☐ No

Alternate Phone: _____
Can we leave a message? ☐ Yes ☐ No

☐ Referring Physician (Name): _____Phone #: _____Fax #:_____

Reason for Referral: _____

Body Part: _____ Is this WC: _____

Length of Symptoms: _____

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

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

Who should we contact to schedule the appointment? ☐ YOUR Clinic ☐ PATIENT

History of MRSA or VRE: ☐ Yes ☐ No

Please indicate if any of the following has occurred:

	Yes	No	Date	Physician/Provider	Clinic/Hospital	City/State
X-rays / MRI						
Physical Therapy/Chiropractor						
Previous Surgeries/Injections						
Previous Care with any Provider						

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

Insurance: _____ NP Packet Sent to Patient YES / NO Staff Initials: _____