Specialty Orthopaedics
Take back your everyday

Physician Referral Form

Tel: **770-532-7202 ext. 1**
Fax: **770-536-2767**

Thank you for referring your patient to Specialty Orthopaedics. Please indicate the specialty to which you are referring your patient:

- ☐ Hand & Upper Extremity
- ☐ Foot & Ankle
- ☐ General Orthopedics
- ☐ Spinal Care
- ☐ Sports Medicine
- ☐ Total Joint Replacement
- ☐ Other_____
- ☐ Specific provider_____

Please provide the following so we can schedule an appointment:

FAX THIS FORM AND PERTINENT MEDICAL RECORDS TO 770-536-2767

O PERTINENT MEDICAL RECORDS

O INSURANCE AUTHORIZATION (IF REQUIRED)

Referring provider information

Name:	Practice:
City, state:	Phone:
Fax:	E-mail:
Office contact:	

Patient information

Patient name:		O M O F
Street address:		
City, state:		Date of birth:
Parent/guardian:		

Please check preferred contact phone number:

O HOME: O CELL: O WORK:

Interpreter needed? O YES O NO LANGUAGE:

Primary Care Provider (IF DIFFERENT FROM REFERRING):

This visit is (MARK ONE):

O **Initial Consultation** O **Semi-urgent** *WITHIN 2 WEEKS O **Urgent** *LESS THAN 48 HOURS

*For urgent appointments, please call **770-532-7202 and select option 1.**

I am requesting: O CONSULT ONLY O RECOMMENDED CARE O REFERRAL REQUESTED BY PATIENT

Patient's medical issue

ICD-10 code:

Please tell us what specific medical issue to address at this visit:

Information check list PLEASE ATTACH (WHERE APPLICABLE):

O PROGRESS NOTES	O PREVIOUS WORK UP FOR THESE SYMPTOMS
O LABS	O MEDICATION LIST, ALLERGIES
O IMAGING	
O OTHER:	

QUESTIONS ABOUT THIS REFERRAL? CALL US AT 770-532-7202 ext 1.