Southeastern Orthopaedics Patient Referral Form

110 Shirley Ave. Douglas, GA 31533
Office (912)383-9789 Fax (912)383-9435

Thank you for your referral!!
We will return/fax this form with the appointment date and time below.

Patient Name:_____.
Patient DOB: _____. Phone # _____.
Address: _____.
Insurance: _____. Policy # _____.
Primary diagnosis or chief complaint:_____.
Referring Physician: _____.
Phone # _____. Fax # _____.
NPI or tax ID: _____.

- ? Has the patient had any studies? (ex. Xrays, MRI, CT etc) If yes, where and when?
  _____
- ? Has the patient ever seen another orthopedist for this problem? If yes, who?
  _____.
- ? Has the patient had any surgery on the chief complaint? If yes, Where and When?
  _____

Please circle:
Which office location? Douglas (mon-fri) or Fitzgerald (Thursday mornings)

Please circle:
Is the referral: Routine (first available) or Urgent

** Please fax supporting office notes and insurance cards with referral form**

Your patient's appointment is scheduled below. Please notify your patient we have scheduled their appointment and we look forward to seeing them!

Appointment Date: _____. Time:_____. Location: Douglas or Fitzgerald