New Patient Referral Form

Bone and Joint Center
3555 S National Avenue, Springfield, MO 65807
Phone: 417-875-3800
Orthopedics & Sports Medicine Fax: 417-875-3838
Physical Medicine & Rehab Fax: 417-269-6865

REFERRING CLINIC INFORMATION

Referring Clinic Name: Date:
Referring Provider Name: Clinic Contact Name:
Phone: Fax:

PATIENT INFORMATION

Patient Name: Patient Date of Birth:
Home Address:
Home Phone: Cell Phone:
Work Phone: ☐Male ☐Female ☐Other (Specify):
Primary Language: Interpreter Needed: ☐Yes ☐No
Contact Name: Contact Relationship:
1st Insurance: Policy: Group:
2nd Insurance: Policy: Group:
Is this a Work Comp related injury? ☐Yes ☐No
If yes, please complete and fax referral to Work Complete at 417-269-2668
Employer Name/Contact information:

REFERRAL INFORMATION

☐First Available Physician ☐Specific Physician requested (if applicable):
Diagnosis/Complaint:

Chronic? ☐Yes ☐No Date of Injury/Symptoms:
Is patient diabetic? ☐Yes ☐No If yes, what is patients most recent A1C and date?
Has the patient had previous surgeries: ☐Yes ☐No
If Yes, Date of procedure: Procedure:
Facility: Surgeon:
Hardware (if applicable):
Include all office notes pertaining to previous surgeries.

This form must be completed and faxed with the following:

1) All office notes pertaining to the diagnosis/reason for referral
2) Any labs and diagnostic testing/imaging pertaining to the diagnosis/reason for referral
3) Patient medication list
4) Copy of patient's insurance card(s) including front and back and valid photo ID

Fax this completed form to:
Orthopedics & Sports Medicine 417-875-3838 or Physical Medicine & Rehab 417-269-6865
The patient will be scheduled as soon as possible and we will notify you of the appointment date and time.
Appointments will not be scheduled until all records are received.

OFFICE USE ONLY
Appointment Information:
Provider: Date: Time:
Patient notified: ☐ Yes ☐ No Staff Initials: