



Serving South Puget Sound with

Quality Orthopaedic Care for Over 35 Years

PHYSICIAN APPOINTMENT REQUEST

By Fax: Eastside (360) 493-0407 Westside (360) 786-9010 Tumwater (360) 528-2830

This form will be returned via fax within 48 hours of receipt. Please indicate return fax number.

Date _____ Referring Dr. Office Contact Person _____
Referring Physician Name _____
Telephone # _____ Fax # _____

Patient Information – PLEASE FAX A COPY OF THE PATIENTS INSURANCE CARDS

Patient's Full Name: _____
Address _____
Home Phone # _____ Daytime # _____
SSN # _____ DOB _____ Gender Male Female
Emergency Contact (For Children Only) _____
Needs Interpreter No Yes If yes which language? _____

Appointment Information:

Type of Injury (Body Part) _____
Desired Time Frame for Patient Appointment _____ 1st Avail. Appt.
Requested Physician _____
Can This Patient be seen by a PA? Yes No
Will the patient be bringing X-rays? Yes No
Where were films taken? _____

Insurance/Workers Compensation Information

Insurance Company Name _____ ID # _____
Insurance Benefit / Verification # _____

For Workers Compensation Patients Only:

Is this a work related injury? Yes No Date of Injury _____
Has a Physicians Initial report / Claim been submitted? Yes No
Employers Name and Phone # _____

For OOA use only: Patient aware of appointment Unable to contact patient
Appointment Date _____ Time _____
Doctor _____ Notes _____

Thank you for your referral!