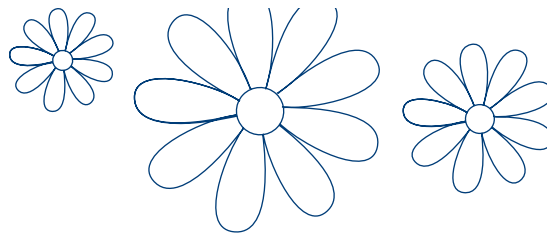


Orthopedics Referral Form



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**PLEASE FAX REFERRAL FORM,
PATIENT DEMOGRAPHICS AND INSURANCE CARD(S)**

Patient name: _____ DOB: _____

Home phone: _____ Cell phone: _____

Insurance: _____

Referring provider office name: _____ Referring provider office phone: _____

Primary care provider name (if different from referring): _____ PCP office phone: _____

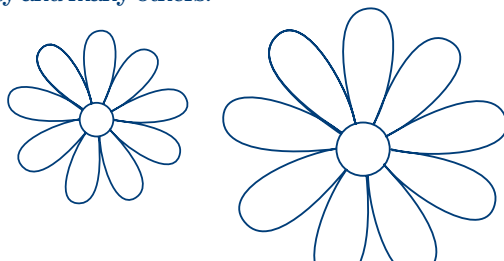
Reason for referral: _____

Relevant labs and/or radiologic findings: _____

Reason for referral/request for consultation/order (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> General orthopedic surgery | <input type="checkbox"/> Joint replacement surgery |
| <input type="checkbox"/> Arthritis and rheumatologic condition | <input type="checkbox"/> Foot and ankle |
| <input type="checkbox"/> Traumatic condition to the musculoskeletal system | <input type="checkbox"/> Pediatric orthopedics |
| <input type="checkbox"/> Sports Medicine | <input type="checkbox"/> Tumors and/or masses of the musculoskeletal system |
| <input type="checkbox"/> Arthroscopic surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Work related injury | |

WE GLADLY ACCEPT MOST INSURANCE PLANS, We accept most major insurance plans, including Blue Cross and Blue Shield of New Mexico, TRICARE, Medicare, all Centennial/Medicaid plans, including Presbyterian Centennial Care, New Mexico Health Connections, True Health New Mexico, United Healthcare, Western Sky Community Care and United Retiree Health Care Authority and many others.



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