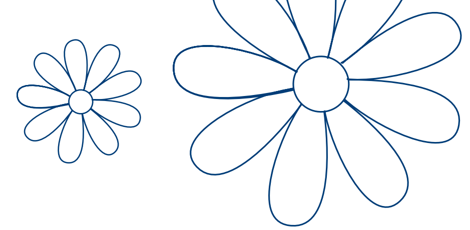

Referral Form
Orthopedics

Jayce Powell, FNP

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Phone: 505.727.4430
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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: ____

____

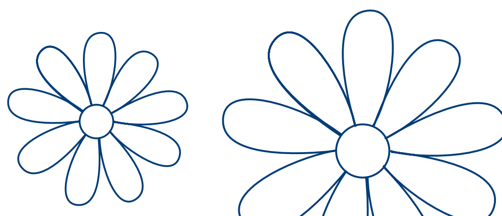
Relevant labs and/or radiologic findings: ______________________________

____

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

- ❑ General orthopedic surgery
- ❑ Arthritis and rheumatologic condition
- ❑ Traumatic condition to the musculoskeletal system
- ❑ Arthroscopic surgery
- ❑ Work-related injury
- ❑ Joint replacement surgery
- ❑ Foot and ankle
- ❑ Tumors and/or masses of the musculoskeletal system
- ❑ Other ______________

We accept most major insurance plans, including Blue Cross and Blue Shield of New Mexico, Aetna Medicare & Commercial, TRICARE, Medicare, all Centennial/Medicaid plans, including Presbyterian Centennial Care, True HEALTH NEW MEXICO, WESTERN SKY COMMUNITY CARE AND UNITED RETIREE HEALTH CARE AUTHORITY AND MANY OTHERS.



Lovelace
Medical Group

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