

Referral Form Orthopedics

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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 (che	
☐ General orthopedic surgery	☐ Joint replacement surgery
☐ Arthritis and rheumatologic condition	☐ Foot and ankle
☐ Traumatic condition to the musculoskeletal system	☐ Pediatric orthopedics
☐ Sports Medicine	☐ Tumors and/or masses of the musculoskeletal system
☐ Arthroscopic surgery	□ Other
☐ 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.





