Compass Orthopedics

AN AFFILIATE OF COMPASS REHABILITATION

REFERRAL FORM

☐ Julie Dodds, MD ☐ Karl Dunn, DPM, FACFAS ☐ David Shneider, MD`

REFERRAL REQUEST ☐ First Available ☐ Urgent ☐ In-Season Athlete

SERVICE REQUEST ☐ Consultation ☐ Consult & Diagnostic Testing ☐ Consult & Treatment ☐ Treatment

REFERRING PHYSICIAN: _____

Contact: _____ Phone: _____ Fax: _____

Primary Care Physician: _____

PATIENT NAME: _____

Parent/Guardian (if minor under 18): _____

Address: _____

City: _____ State: _____ Zip Code:_____

DOB: _____Social Security: _____ Phone: _____ Cell: _____

REASON FOR REFERRAL: _____ Date of Injury: _____

Previous Surgery ☐ Yes ☐ No If Yes, Date: _____ Physician: _____

Attach All Relevant Medical Records: Insurance Cards, Visit Notes, Recent X-Ray, MRI, EMG and CT Studies

INSURANCE INFORMATION:

Auto or Work Comp: ☐Yes ☐ No If Yes, Company: _____

Claim #:_____ Case Manager: _____ Phone: _____

Insurance Auth # (if required): _____

Primary Insurance: _____ Phone: _____

Address: _____

City, State, Zip Code: _____

Subscriber: _____ Date of Birth: _____

Contract Number: _____ Group Number: _____ Relationship to Patient: _____

Secondary Insurance: _____ Phone: _____

Contract Number: _____ Group Number: _____ Relationship to Patient: _____