COLUMBIA ORTHOPAEDIC GROUP

1 South Keene Street Columbia, Missouri 65201 Main Ph (573)443-2402
Referring Physician Hotline (573) 441-3759 Referring Physician Fax# (573) 876-8140

Referral Form

Referring Provider _____ *Phone* _____

Name of Office Staff making request & phone _____

✓ Patient Name (First and Last) _____
✓
✓ Date of Birth: _____ Age _____ Last 6 numbers of SSN _____
✓
✓ Cell Phone _____ Home Phone _____
✓
✓ Body Part(s) we are evaluating? _____
✓
✓ Previous surgery on this body part? ☐ No ☐ Yes If yes, what?_____
✓
✓ X-rays done of this area? ☐ No ☐ Yes (If so, please have pt bring a copy)
✓
✓ Old Injury? ☐ No ☐ Yes (date _____) New Injury? ☐ No ☐ Yes (date _____)
✓
✓ Work Comp? ☐ No ☐ Yes Date of Injury _____
✓
✓ Health Insurance _____
✓ (If referral needed please fax to 573-876-8140)

First Appropriate Provider Available? ☐ No ☐ Yes Specific Provider? _____

☐ Email or ☐ Fax number to send confirmation of patient's appointment? _____

Any additional info you think we might find usual? _____

_____

_____

_____

You can expect a return confirmation as soon as possible/same day. Thank you for your trust.