CONSULTATION REQUEST
DATE:_____

ORTHOPEDIC ASSOCIATES OF MEADVILLE P.C
Phone (814) 724-1252 Fax (814) 337-6043

1. PATIENT INFORMATION: ***> Referring physicians office please fill out blocks 1 – 3 <***

Full Name:_____ DOB:_____ /_____ /_____ SS#: _____-_____-_____

Address:_____ _

Phone _____ Alt Phone_____ PCP: _____

Is this a work related injury? Y / N **Is this an Auto related injury? Y / N** **Current/Pending Litigation? Y/N**

*If yes: Ins Carrier_____Claim#_____State_____ DOI_____

2. INSURANCE INFORMATION:

Some insurance plans require authorization numbers prior to scheduling Auth # (if applicable) _____

Primary Ins _____ ID# _____ Group#_____

Secondary Ins _____ ID# _____ Group#_____

Subscriber Name_____ DOB_____/_____/_____ Relationship _____

3. REFERRING PHYSCIAN INFORMATION:

Reason for consultation_____ [ ] Chronic [ ] Acute **(check one)**

Referring Physician_____ Contact Person_____

Fax # _____ Phone# _____

PLEASE SEND MOST RECENT RECORDS WITH THIS FORM. THE PATIENT WILL BE CONTACTED BY OUR OFFICE TO SCHEDULE AN APPOINTMENT. WE WILL NOTIFY YOU OF THE SCHEDULED APPOINTMENT VIA FAX OR PHONE*

PEASE SEND > ____Completed Consult Form ____Medication List ____Radiology Reports (CT/MRI/XR within 1yr)

____Bloodwork ____Office Notes ____Other Pertinent Testing

____ Pre/Post Op Images/Reports

4. OAM USE ONLY **OAM ID#_____** **Appt Date:_____** **Time:_____** **Provider ID_____**

1.	Recent testing for this condition?	Y / N	_____
2.	History of infection in joint?	Y / N	_____
3.	Previous surgery for this condition?	Y / N	_____
4.	H/O injections or pain management?	Y / N	_____
5.	Is this a 2nd opinion?	Y / N	_____
6.	Open wounds?	Y / N	_____
7.	Diabetic?	Y / N	_____
8.	Patient to have records sent?	Y / N	Received? Y / N Reviewed By:_____
9.	Appointment scheduled ?	Y / N	If no, reason: _____

[Revised 3/16]