Seth Criner, D.O.

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REFERRAL REQUEST

REFERRAL INFORMATION

Requesting Physician: _____ Date of Referral: _____

Contact: _____ Phone: _____ Fax: _____

Patient Name: _____ Date of Birth: _____ SSN#: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Cell / Message: _____

Employer: _____ Employer Phone: _____

Reason for Referral: ☐ Consultation ☐ Second Opinion ☐ Consult and Treatment

INSURANCE INFORMATION

Insurance: _____ Subscriber #: _____

W/C Carrier: _____ Phone: _____ Adjuster: _____

Address: _____ City: _____ Zip: _____

DOI: _____ CL#: _____

Authorized by: _____ Date: _____

Please FAX the *following information* along with this form as applicable:

- **Reason for Consult** *(Diagnosis):* _____
- **Current History and Physical**
- **All Applicable Test Results**
  Please check applicable: ☐ MRI ☐ CT Scan ☐ X-Ray ☐ EMG Nerve Conduction Study
- **Copy of Insurance Information and Authorization form** *(if required)*

To Our Valued Referring Practices:

In order to facilitate a smooth patient visit, please remind the patients to bring pertinent radiographs and MRI images with them to their orthopaedic appointment. Our surgeons prefer to review the images directly in order to best diagnose and plan any surgical treatment for our patients.

Though we can often view images on the internet some centers do not offer us access and having the studies in hand will make the visit smoother. This will avoid unnecessary delays in diagnosis and treatment. We will contact the patients directly and inform them of this but any assistance from your office would be greatly appreciated.

Thank you for the privilege of taking care of your patient.

For Office Use Only:

Referral Received: _____ Appointment Date: _____ Time: _____

Patient Notified: _____ Referring M.D. Notified: _____