Referral Form

Southeastern Orthopaedics
Southeastern Orthopaedics Surgery Center

110 Shirley Avenue Douglas, GA 31533
Office (912) 383-9789 Fax (912)383-9435

We will return/fax this form with the appointment date and time below.

Referring Physician: _____

Phone: _____Fax: _____

NPI: _____

Patient Name: _____

Patient DOB: _____ Phone: _____

Address: _____

Insurance:_____ Policy: _____

Primary diagnosis or chief complaint: _____

**** Please fax supporting office notes and insurance cards with referral form****

- Has the patient had any studies? (ex. Xrays, MRI, CT, EMGs) If yes, where and when?

  _____

- Has the patient ever seen another orthopedist for this problem? If yes, who?

  _____

- Previous surgery on the chief complaint? If yes, Where and When?

  _____

Preferred office location? Douglas (mon-fri) or Fitzgerald (Thursday mornings) or Alma (Monday mornings)

Please circle: Routine (first available) or Urgent

Your patient's appointment is scheduled below. We look forward to seeing them. We will contact the patient.

Appointment Date: _____Time:_____

Location Scheduled: Douglas Fitzgerald Alma