TALLGRASS
ORTHOPEDIC &
SPORTS MEDICINE

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Orthopedic Consultation Request

Please complete the following information and fax to **(785) 233-3187**. We will attempt to contact the patient to arrange for an appointment time within 24 hrs. of receipt of this request.

Date: _____ Provider Requesting Consultation: _____

Orthopedic Physician Requested: _____

Patient Name: _____DOB:_____

Injury / Onset Date: _____ Responsible Party: _____

Home Phone #_____ Cell Phone # _____

Insurance Info: _____

Reason for Consultation: _____

Has the patient had any of the following: XRAY MRI CT Bone Scan Other: _____

- If the patient has had imaging studies within the past six months completed anywhere other than St. Francis Health Center, we ask that the patient hand-carry these to their appointment. If the studies are not available at the time of the appointment, it may need to be rescheduled.

  Is this complaint work related? YES _____ NO _____
  Is this complaint related to an auto accident? YES _____ NO _____
  Is there an attorney involved? YES _____ NO _____

- If this complaint is work related, please ask the patient to provide us with a copy of the "Report of Injury" submitted to their employer at the time of their appointment.
- If this complaint is related to an auto accident or is work related, all the billing information needs to be submitted to us before we are able to schedule the appointment.
- **Please send patient demographic information, copy of insurance card, recent progress note, and all imaging study reports with this Consultation Request Form.**

If you would like to receive confirmation of the appointment given, please complete below:

Referring Contact Person: _____

Referring Contact Phone #_____ Fax # _____

FOR TALLGRASS USE ONLY:
Appt Date: **Appt Time:** **DR/PA:**
Location: **Initials:**