CAROLINA BONE & JOINT
ORTHOPEDICS RHEUMATOLOGY PAIN MANAGEMENT

Injury Medicine Referral Form

Fax – 704-289-3076
Or via email @ rperez@bonesrus.org

1. Patient Information:

Patient Name:_____ Male / Female Date of Injury : _____

Patient Mailing Address:_____ City, State, Zip: _____

Phone: _____ DOB: _____ Social Security #: _____

Referred by: _____ Referring Provider Fax #: _____

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2. Patient Intake Questionnaire: **(please circle)**

1. Were you injured in an auto accident? ☐ Yes ☐ No

2. Are you represented by an attorney? ☐ Yes ☐ No

Law Firm Name:_____ Law Firm Telephone:_____

Firm Address: _____ City, State, Zip:_____

3. Do you have private / commercial health insurance as Primary Coverage? ☐ Yes ☐ No
(for example: BCNS, United healthcare, Cigna, Aetna or other)
Name:_____ID#_____Group#_____Phone#_____

4. Do you have private / commercial health insurance as Secondary Coverage? ☐ Yes ☐ No
Name:_____ID#_____Group#_____Phone#_____

5. Are you covered by Medicaid? ☐ Yes ☐ No

6. Are you covered by Medicare? ☐ Yes ☐ No

7. Is your treatment covered by worker's compensation? ☐ Yes ☐ No
If yes, Name:_____Address:_____

Claim#:_____Phone#:_____Adjuster:_____

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3. Present Complaints:

Please Describe: _____

Did you go to the hospital? ☐ Yes ☐ No (If Yes, where?)_____

Have you received any other medical care? ☐ Yes ☐ No (If so, Name & Phone# of other doctors) -

_____

_____

Location Requested: (check one) ☐ **Charlotte** ☐ **Monroe** ☐ **Greensboro** ☐ **Columbia, SC**

Appointment Scheduled: **Date:** **Time:** _____