

MIDLANDS **orthopaedics** & NEUROSURGERY

Sports Medicine

Robert M. DaSilva, MD
Bernard G. Kirol, MD
James A. O'Leary, MD
Bradley S. Aspey, MD
Thomas D. Armsey, II, MD

Upper Extremity

Michael S. Green, MD
Seth H. Bowman, MD

Neurosurgery

William M. Rambo, Jr., MD
Karl A. Lozanne, MD
Seth S. Molloy, DO

Total Joint

Replacement
Thomas P. Gross, MD
Coleman D. Fowble, MD
Slif D. Ulrich, MD
D. Scott Schultz, Jr., MD

Foot and Ankle

William C. James, III, MD
Jeremy M. Saller, MD

Adult Spine

Ivan E. LaMotta, MD

www.midorthoneuro.com

Pain Management

Jenna L. Walters, MD

Physical Medicine & Rehabilitation

Simonne C. Francis, MD

DOWNTOWN
1910 Blanding St
Columbia, SC 29201

IRMO
1013 Lake Murray Blvd
Irmo, SC 29063

4 LOCATIONS
phone: 803-256-4107
referral/appointment fax: 803-254-2825

LEXINGTON
109 Park Place Ct
Lexington, SC 29072

NORTHEAST
114 Gateway Corporate Blvd
Ste 110, Columbia, SC 29203

NEW PATIENT APPOINTMENTS

Today's Date: _____

IS THIS A(N) **NEUROSURGICAL** **ORTHOPAEDIC** **SPINE** **REFERRAL REQUEST?**
 MD Requests consult with Dr. _____ No MD preference – Requests 1st available

PATIENT NAME: _____

SS#: _____ - _____ - _____ **DOB:** _____

ADDRESS: _____
(Street) (City) (State/Zip)

HOME PHONE: () _____ **WORK:** () _____ **CELL:** () _____

PATIENT EMAIL ADDRESS: _____

DX: (please specify) _____

How long has the patient had this problem? _____

Has patient had scans or x-rays? Yes No If yes, please specify _____

PLEASE INFORM PATIENT TO BRING ANY FILMS TO THE APPOINTMENT

INS. AUTH REQUIRED? Yes No Auth# _____

INSURANCE 1: _____

INSURANCE 2: _____

***(Please include a front and back copy of all insurance cards. If insurance is Medicaid, please include patient's Medicaid number above. If the patient's insurance requires a referral, please fax to the number at the top of this page as soon as possible.)**

IS A TRANSLATOR NEEDED? YES NO **IS AN ATTORNEY INVOLVED?** YES NO

IS THIS WORK COMP RELATED? YES NO **IS THIS MOTOR VEHICLE RELATED?** YES NO

HAS THE PATIENT SEEN ANOTHER ORTHOPAEDIST OR NEUROSURGEON FOR THIS PROBLEM? YES NO

IF SO, HOW LONG AGO? _____

REFERRING PROVIDER: _____ **Office Contact:** _____

PHONE: _____ (EXT) _____ **FAX:** _____

FAX # TO SEND COMPLETED OFFICE NOTES (IF DIFFERENT FROM ABOVE): _____

*** Please fax the following information along with this completed form:**

1) Any records including most recent MRI or other Scan report 2) Copy of front & back of all insurance cards

**** If you have not received appointment information from us within 48 hrs., please call.**

For Midlands Orthopaedics & Neurosurgery use: APPOINTMENT INFORMATION: (appt date, time, physician, location)