Sports Medicine
Robert M. DaSilva, MD
Bernard G. Kirol, MD
James A. O'Leary, MD
Bradley Aspey, MD
Thomas D. Armsey, II, MD
Adam T. Griffith, MD

Adult Spine
Ivan E. LaMotta, MD

Upper Extremity
Seth H. Bowman, MD
Tyler C. Miller, MD

Foot and Ank le
William C. James, III, MD

MIDLANDS orthopaedics & NEUROSURGERY

www.midorthoneuro.com

4 LOCATIONS

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

Neurosurgery
Larry R. Shannon, II, MD
Karl A. Lozanne, MD
Seth S. Molloy, DO

Physical Medicine and Rehabilitation
Simmone C. Francis, MD

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

Pain Management
Jenna Walters Lambeth, MD

DOWNTOWN
1910 Blanding St
Columbia, SC 29201

IRMO
1013 Lake Murray Blvd
Irmo, SC 29063

LEXINGTON
109 Park Place Ct
Lexington, SC 29072

NORTHEAST
114 Gateway Corporate Blvd
Ste 110, Columbia SC 29203

****IS THIS A 2ND OPINION REQUEST? YES / NO IF YES, HAS THE PATIENT HAD SURGERY? YES / NO**

WE WILL NEED ALL RECORDS INCLUDING (BUT NOT LIMITED TO) ALL CLINICAL NOTES RE: SPECIFIED ISSUE, ANY SURGERY RECORDS, AND ANY IMAGING INCLUDING DISC ** RECORDS CAN BE FAXED TO 803-933-6352 OR EMAILED TO newopinion@midorthoneuro.com FOR 2ND OP REQUESTS

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: _____ GENDER M or F

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? Y/N If yes, please specify _____

PLEASE INFORM PATIENT TO BRING ANY FILMS TO THE APPOINTMENT

INS. AUTH REQUIRED? Y/N Auth# _____

INSURANCE 1: _____ In/Out of Network?

INSURANCE 2: _____ In/Out of Network?

*(Please include a front and back copy of all insurance cards. If insurance is Medicaid, please include patient's Medicaid number above.

PLEASE NOTE: WE DO NOT ACCEPT ADULT MEDICAID OR DUAL PLANS AT THIS TIME

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 ORTHO OR NEURO FOR THIS PROBLEM IN THE PAST 10 YEARS? YES / NO

IF SO, BY WHOM? _____

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

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