MIDLANDS orthopaedics & NEUROSURGERY

WORKERS' COMP PATIENT REFERRAL

Phone: 803.256.4107 Ext. 3009
Fax: 803.462.3647
midlandscomp@midorthoneuro.com

ALL INFORMATION MUST BE OBTAINED PRIOR TO MAKING APPOINTMENT

☐ M ☐ F Patient Name: _____ Email _____

Daytime Phone #_____ Patient Address: _____

City/St/Zip:_____ Patient SS#:_____

Patient DOB:_____DOI: _____

Body Part/ Side:_____ State injury occurred:_____

How Injury Occurred _____

Employer at Time of Injury:_____Phone #_____

Employer Address:_____ City/St/Zip_____

Worker's Comp Carrier: _____Claim #:_____

Claims Address:_____City/St/Zip_____

Therapy Network_____DME Network_____Imaging Network_____

Adjuster Name_____Adjuster Phone_____

Adjuster E-mail_____Adjuster Fax: _____

Case Manager Name_____Case Mgr Phone:_____

Case Mgr E-mail:_____Case Mgr Fax:_____

IME only IME with treatment Consult Only Consult with treatment Injection
Authorization for patient to be seen by PAs as needed per physician

Other_____

Referring Physician:_____ Referring Physician Contact: _____

Referring Physician Phone #_____ Fax #:_____

Patient Attorney: _____ Phone:_____Fax:_____

Have x-rays/MRI been taken since this injury Occurred: ☐ Yes ☐ No (*If yes, films must accompany Patient to appt.*)

Has treatment been rendered for this injury: ☐ Yes ☐ No (*If yes, records must accompany Patient to appt.*)

Comments:

Please send all medical records to midlandscomp@midorthoneuro.com