NORTHWEST ORTHOPAEDIC SPECIALISTS

Refer a Patient

Section 1: Patient Information *(Required)*

Name _____ Home Phone _____

Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Email _____

Gender ☐ **M** ☐ **F** Insurance _____

Symptoms & Diagnosis _____

_____

Was this injury/condition related to Workers' Compensation? ☐ **Yes** ☐ **No**

Patient has completed: ☐ **Bone Scan** ☐ **CT Scan** ☐ **MRI** ☐ **EMG** ☐ **X-Ray** ☐ **Cast/Splint**

Patient's preferred location: ☐ **North Clinic** ☐ **Valley Clinic** ☐ **Downtown Clinic** ☐ **Interventional Pain**

Does the patient have a request for a specific provider? ☐ **No** ☐ **Yes,** _____

Section 2: Referring Physician Contact Information *(Required)*

Referring Provider _____ Contact Name _____

Phone Number _____ Email _____

Fax Number _____

Thank you for entrusting Northwest Orthopaedic Specialists with your patients.

This completed form can be faxed to the preferred location fax number (listed below).
We will contact your patient directly to schedule an appointment within 48 hours.

North Clinic	Valley Clinic	Downtown Clinic	Interventional Pain
509-465-1313	509-928-7893	509-624-9179	509-462-1470