DownEast Orthopedic Associates, P.A.
78 Ridgewood Drive Bangor, Maine 04401
Orthopedic Consultation Request Form

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Please check the physician name you are requesting and fax the completed form along with a completed medication list, pertinent office notes, labs, EMG's, radiology, MRI, CT reports, copy of the **health insurance card**, and any managed care insurance referral to Jennifer *at* ***942-5631***. Jennifer can be reached at 307-8950 or jlane@downeastortho.com

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P. Gregory Askins, MD	D. Thompson McGuire, MD	Cameron Trubey, MD
Jacob Brooks, DO	Kenneth Morse, MD	Stephen Walsh, MD
Garrett Martin, MD	John Pyne, MD	First Available

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Date:__________ Referring Physician:______________________ Phone #:______________
Contact Name:______________________ Ext. #:____________ Fax #:______________
Primary Care Provider:____________________ Phone:_____________ Fax:______________
Patient Name:_________________________ DOB:_________ SSN #:____-_____-____ Sex:___
Address:__________________________ City/State:_______________________ Zip:________
Home Phone:____________________ Work::____________________ Cell:_______________
Employer:____
Reason for Consultation:____

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Please circle: Work Related Auto Accident Liability None
Has there ever been a claim filed for this diagnosis? Yes No
If yes, please circle: Open Active Claim Settled Contested Denied
WC/MVA Carrier Name:____
Carrier Address:____
Claim #:____________________________ DOI:______________________________________
Adjuster Name:________________________ Phone:___________________ Ext #:__________

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Primary Health Insurance:________________________ Policy #:___________________
Group #:___________________ Subscriber Name:___________________________________
DOB:___________ SSN:_________________ Pt relationship to Sub:__________________
Secondary Insurance:_________________________ Policy #:______________________
Group #:___________________ Subscriber Name:___________________________________
DOB:___________ SSN:_________________ Pt relationship to Sub: _________________
Insurance Authorization #_____________________________ Number of visits:_______________
From (date):_________________________ Through (date):__________________________

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Outside Referring Providers are responsible for getting this visit authorized with an authorization number faxed with this consult form before an appointment will be booked. If this is a workers comp claim we must have **written** authorization from the adjuster via email or fax prior to an appointment being booked.

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For Orthopedic office use only:

Appt Date:________________ **Time:**________________ **W/Dr.:**______________________