

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

\*\*\*\*\*

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 Katelyn at **942-5631**. Katelyn can be reached at (207) 307-8948 or [kallen@downeastortho.com](mailto:kallen@downeastortho.com)

\*\*\*\*\*

1 <sup>st</sup> Available	Garrett Martin, MD	Kenneth Morse, MD
John Pyne, MD	Jacob Brooks, DO	D. Thompson McGuire, MD
P. Alex Green, MD	Stephen Walsh, MD	Cameron Trubey, MD
Timothy Allen, MD	Tony Tsismenakis, MD	Joshua Vaughn, MD

\*\*\*\*\*

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: \_\_\_\_\_

\*\*\*\*\*

**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 #: \_\_\_\_\_

\*\*\*\*\*

**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): \_\_\_\_\_

\*\*\*\*\*

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.

\*\*\*\*\*

**For Orthopedic office use only:**

Appt Date: \_\_\_\_\_ Time: \_\_\_\_\_ W/Dr.: \_\_\_\_\_