

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, radiology, MRI, CT reports, copy of the **health insurance card**, and any managed care insurance referral to the Referrals Department at **942-5631**.

Referrals Phone: 207-947-8381 Option 5 referrals@downeastortho.com

John Pyne, MD	Jacob Brooks, DO	Kenneth Morse, MD
Elizabeth Truelove, MD	Stephen Walsh, MD	D. Thompson McGuire, MD
P. Alex Green, MD	Tony Tsismenakis, MD	Cameron Trubey, MD
Timothy Allen, MD		Jessica Lucas, DO

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.

Appt Date: _____ **Time:** _____ **W/Dr.:** _____