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

****

P. Alex Green, MD	Jacob Brooks, DO	Kenneth Morse, MD
Timothy Allen, MD	Stephen Walsh, MD	D. Thompson McGuire, MD
Elizabeth Truelove, MD	Tony Tsismenakis, MD	Cameron Trubey, MD
Travis Wright, MD	Jason Lang, 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.:**_____