Sports Medicine
Robert M. DaSilva, MD
Bernard G. Kirol, MD
James A. O'Leary, MD
Bradley S. Aspey, MD
Thomas D. Armsey, II, MD

Upper Extremity
Michael S. Green, MD
Michael R. Ugino, MD
Seth H. Bowman, MD

Adult Spine
Ivan E. LaMotta, MD

MIDLANDS orthopaedics & NEUROSURGERY

Neurosurgery
Thomas J. Holbrook, Jr., MD
William M. Rambo, Jr., MD
Karl A. Lozanne, MD
Matthew T. Brown, MD

Total Joint Replacement
Thomas P. Gross, MD
Coleman D. Fowble, MD
Slif D. Ulrich, MD

Foot and Ankle
William C. James, III, MD

Pediatric Orthopaedics
Frederick C. Piehl, MD

www.midorthoneuro.com

Pain Management
Eva Jane Rawl, MD

Physical Medicine and Electrodiagnosis
Ryan A. Wetzel, MD

DOWNTOWN
1910 Blanding St
Columbia, SC 29201

IRMO
1013 Lake Murray Blvd
Irmo, SC 29063

4 LOCATIONS
phone: 803-256-4107
referral/appointment fax: 803-254-2825

LEXINGTON
109 Park Place Ct
Lexington, SC 29072

NORTHEAST
114 Gateway Corporate Blvd
Ste 110, Columbia SC 29203

NEW PATIENT APPOINTMENTS

Today's Date: _____

IS THIS A(N) ☐ ORTHOPAEDIC OR ☐ NEUROSURGICAL REFERRAL REQUEST?

☐ **MD Requests consult with Dr.** Select Physician _____ ☐ **No MD preference – Requests 1st available**

PATIENT NAME: _____

SS#: _____ - _____ - _____ **DOB:** _____ ☐ Male ☐ Female

ADDRESS: _____
(Street) (City) (State/Zip)

HOME PHONE: ( ) _____ **WORK:** ( ) _____ **CELL:** ( ) _____

PATIENT EMAIL ADDRESS: _____

DX: (please specify) _____

How long has the patient had this problem? _____

Has patient had scans or x-rays? ☐ Yes ☐ No If yes, please specify _____

PLEASE INFORM PATIENT TO BRING ANY FILMS TO THE APPOINTMENT

INS. AUTH REQUIRED? ☐ Yes ☐ No **Auth#** _____

INSURANCE 1: _____ ☐ IN ☐ OUT of NETWORK

INSURANCE 2: _____ ☐ IN ☐ OUT of NETWORK

*(**Please include a front and back copy of all insurance cards.** If insurance is Medicaid, please include patient's Medicaid number above. If the patient's insurance requires a referral, please fax to the number at the top of this page as soon as possible.)

IS A TRANSLATOR NEEDED? ☐ YES ☐ NO **IS AN ATTORNEY INVOLVED?** ☐ YES ☐ NO

IS THIS WORK COMP RELATED? ☐ YES ☐ NO **IS THIS MOTOR VEHICLE RELATED?** ☐ YES ☐ NO

HAS THE PATIENT SEEN ANOTHER ORTHOPAEDIST OR NEUROSURGEON FOR THIS PROBLEM? ☐ YES ☐ NO

IF SO, HOW LONG AGO? _____

REFERRING PROVIDER: _____ **Office Contact:** _____

PHONE: _____ **(EXT)** _____ **FAX:** _____

FAX # TO SEND COMPLETED OFFICE NOTES (IF DIFFERENT FROM ABOVE): _____

*** Please fax the following information along with this completed form:**
1) Any records including most recent MRI or other Scan report **2) Copy of front & back of all insurance cards**
**** If you have not received appointment information from us within 48 hrs., please call.**

For Midlands Orthopaedics & Neurosurgery use: APPOINTMENT INFORMATION: (appt date, time, physician, location)