MIDLANDS ORTHOPAEDICS & NEUROSURGERY, P.A.
Emergency Appointment Request Fax Form

FAX (803) 251-5220 – TRIAGE DEPARTMENT

TODAY'S DATE_____ REFERRING PHYSICIAN _____

REFERRING PHYSICIAN CONTACT NAME_____PHONE # _____

PATIENT'S NAME _____ DOB_____ □ MALE □ FEMALE

PATIENT'S DAYTIME PHONE # _____

NAME AND PHONE NUMBER OF PERSON YOU WANT NOTIFIED OF THIS APPOINTMENT (IF NOT PT)

NAME: _____ PHONE #: _____

MIDLANDS ORTHOPAEDICS & NEUROSURGERY OFFICE LOCATION TO WHICH THE PATIENT IS CLOSEST:

☐BLANDING ☐IRMO ☐NORTHEAST ☐ LEXINGTON ☐WEST COLUMBIA

REASON FOR REFERRAL (LIST BODY PARTS EFFECTED) _____

NATURE OF PROBLEM _____

HOW INJURY OCCURRED _____

WHEN INJURY OCCURRED (IF ACUTE) OR SYMPTOMS BEGAN (IF CRONIC)_____

_____

REFERRING PHYSICIAN REQUESTING CONSULT? _____YES _____NO

IF FRACTURE: ☐ DISPLACED ☐ NON-DISPLACED

IS PATIENT DIABETIC? ☐ YES ☐ NO

NAME OF PATIENT'S INSURANCE COMPANY? _____

IF THIS IS A WORKER'S COMP INJURY, PLEASE COMPLETE THE FOLLOWING:

EMPLOYER NAME: _____ PHONE #: _____

NAME OF CONTACT AT WORK WHO CAN VERIFY WORKER'S COMP: _____

FOR OFFICE USE ONLY:

Time rec'd: _____ By whom: _____ Time call ret'd:_____Prev MON MD: _____

Is PT ambulatory? ____ Transport via EMS? _____ Disposition of call: _____

04/17/2017 Updated