Workers' Comp Referral Form for Triangle Region of EmergeOrtho

Please email form along with medical records to workerscomp@emergeortho.com.

Please use this form to refer all workers' compensation patients to our office.

PATIENT INFORMATION

☐ New Patient ☐ 2nd Opinion / IME

First name:

Last name:

Date of Birth:

Social Security #:

Address:

City:

State: Zip:

Phone:

Email:

EMPLOYER INFORMATION

Employer:

Employer Contact:

Address:

City:

State: Zip:

Phone: Fax:

WORKERS'COMP BILLING INFO

Workers' Comp Carrier:

Date of injury:

Claim#

NC Claim: ☐ Yes or ☐ No

Billing Address:

City:

State: Zip:

Adjuster's Name:

Phone: Fax:

Case Manager's Name:

Phone: Fax:

Email:

DIAGNOSIS & REFERRING FACILITY INFO

Diagnosis/Injured body part:

Referring Facility:

Phone:

EMAIL ALL PERTINENT OFFICE NOTES, BILLING INFO, AND WORKERS' COMP WRITTEN AUTHORIZATION TO OUR OFFICE AT Workerscomp@emergeortho.com ALONG WITH THIS COMPLETED FORM. Imaging CDs must accompany patient to appointment. Please document patient's name, DOB and ALL workers' comp billing info along with the reason for the referral.

*****INCOMPLETE INFORMATION WILL DELAY PATIENT SCHEDULING*****

EmergeOrtho