NORTHWEST ORTHOPAEDIC SPECIALISTS

Refer a Patient

Section 1: Patient Information *(Required)*

Name _____

Address _____

City _____ State ____ Zip____

Date of Birth _____

Gender ☐ **M** ☐ **F**

Home Phone _____

Work Phone _____

Cell Phone _____

E-Mail _____

Insurance _____

Symptoms & Diagnosis _____

_____

Was this injury/condition related to Workers' Compensation? ☐ **Yes** ☐ **No**

Patient has completed: ☐ **Bone Scan** ☐ **CT Scan** ☐ **MRI** ☐ **EMG** ☐ **X-Ray** ☐ **Cast/Splint**

Patient's preferred clinic location: ☐ **Downtown Spokane** ☐ **North Spokane** ☐ **Spokane Valley**

Does the patient have a request for a specific doctor? ☐ **No** ☐ **Yes,** _____

Section 2: Referring Physician Contact Information *(Required)*

Referring Physician _____

Phone Number _____

Fax Number _____

Contact Name _____

Email _____

Thank you for entrusting Northwest Orthopaedic Specialists with your patients.

This completed form can be faxed to the preferred clinic fax number (listed below).
We will contact your patient directly to schedule an appointment within 48 hours.

Downtown	North Spokane	Spokane Valley
509-624-9179	509-465-1313	509-928-7893