Workers' Compensation Referral Form

****** When referring a patient to Triangle Orthopaedics, please complete the following referral form and fax to 919-281-1799 Attn: Workers Comp Dept. or email to WorkersComp@EmergeOrtho.com******

Patient's Name: ______________________________

Social Security Number: ______________ **Date of Birth:** ______________

Home Address: ______________ **Zip Code:** ______________

Phone: ______________ **Alternate Phone:** ______________

Patient's Email Address: ______________________________

How did you hear about Triangle: ______________________________

Employer: ______________________________

Employer Address: ______________________________

Contact: ______________________________

Phone: ______________ **Fax:** ______________

Worker's Compensation Insurance: ______________________________

Billing address for insurance: ______________________________

WC insurance adjuster: ______________ **Phone#** ______________

Adjuster Fax#: ______________ **Email:** ______________

Case manager name: ______________ **Phone:** ______________

Fax # ______________ **Email:** ______________

Who authorized Treatment to EmergeOrtho? ______________ **Phone:** ______________

Preferred Location to Treat: ______________ **Preferred Provider:** ______________

Date of Injury: ______________ **Injured Body Part(s):** ______________

Claim Number: ______________ **State of WC Claim:** ______________

Has the patient received any prior treatment? (ER, Urgent Care, Orthopedist, Neurologist, Surgery, etc.)

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CD OF ANY X-RAYS OR MRI'S MUST COME WITH PATIENT TO APPT.

PLEASE FAX ALL MEDICAL RECORDS TO 919-281-1799

Referring Doctor/Clinic: ______________________________
Phone/Fax: ______________________________

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