



Southlake Orthopaedics

Sports Medicine and Spine Center

a division of **SOA**

Hoover • 4517 Southlake Pkwy • Hoover, AL 35244

Grandview • 3686 Grandview Parkway, Suite 430 • Birmingham, AL 35243

PHYSICIAN REFERRAL REQUEST

(Phone) 205-985-4111

(Fax) 205-267-4411

Patient Information:

Date: _____

Name: _____ DOB: _____

Address: _____

Phone: _____ Secondary Phone (Mobile): _____

Primary Insurance Carrier: _____

Appointment Type:

☐ Please schedule first available appointment with any of the physicians.

☐ Specific Physician Requested: **please check requested provider**

☐ Next Available ☐ Urgent-within 1 week ☐ Emergency (within 48 hours): Contact Office 205-985-4111

Location Desired:

☐ Grandview

☐ Hoover

* Physician sees patients at both locations.

☐ **Ekkehard Bonatz, MD*** Orthopaedic Surgeon (Hand/Elbow)

☐ **William Krauss, DO*** Orthopaedic Surgeon (Foot/Ankle)

☐ **Adam Lukasiewicz, MD, MSc*** Orthopaedic Surgeon (Foot/Ankle)

☐ **William Craig, MD** Spine Non-Surgical/Musculoskeletal Pain

☐ **Jonathon Whitehead, MD*** Orthopaedic Surgeon (Hand, Elbow, Shoulder)

☐ **John Kirchner, MD*** Orthopaedic Surgeon (Foot/Ankle)

☐ **Jonathan Isbell, MD*** Orthopaedic Surgeon (Hip, Knee, Elbow, Shoulder)

☐ **Michael Blum, MD** Orthopaedic Surgeon
(Hip, Shoulder, Knee, Foot, Ankle, Joints)

☐ **Michael Ellerbusch, MD** Sports Medicine/EMG/NCS/Non-Surgical

☐ **George Robert Booker, MD** Orthopaedic Surgeon
(Hip, Shoulder, Knee, Hand, Foot, Ankle, Joints)

☐ **Michael Smith, MD*** Orthopaedic Surgeon
(Hand, Elbow)

☐ **Christopher Heck, MD*** Orthopaedic Surgeon (Spine/Neck)

☐ **Dewey Jones IV, MD** Orthopaedic Surgeon (Hip, Knee, Shoulder)

☐ **Beau Grantier, MD** Sports Medicine/Non-Surgical

Type of Referral

☐ Evaluation consultation with treatment recommendations that primary care physician will continue to follow.

☐ Evaluation consultation with assumed care for this condition.

☐ Evaluation consultation with treatment recommendations and shared care.

☐ Specialist to Specialist* —Secondary Referral ☐ Send Copy of this referral to patients primary care physician.

☐ Other (designate) _____

Workers' Compensation Information (Must be completely filled out if Workers' Comp)

Adjusters Name, Phone# and Email: _____

Employer's Name: _____

Employer's Phone #: _____ Claim number: _____ Date of Injury: _____

Employer's Address: _____

Imaging Available? ☐ Yes ☐ No Type: ☐ MRI ☐ CT ☐ X-ray ☐ Other: _____

Location done: _____

Office Notes/Imaging Reports Faxed: ☐ Yes ☐ No

Reason for Referral: _____

Referring Physician & Contact #: _____ NPI# _____

Referral Coordinator/Fax Contact: _____ Phone# _____

Southlake Orthopaedics IN-OFFICE use only

THANK YOU FOR YOUR REFERRAL: Scheduler Name: _____ Date: _____

☐ Appointment scheduled for Date: _____ Time: _____

☐ Unable to contact patient at above telephone numbers.

You will receive a faxed copy of referral request for your record.

Southlakeorthopaedics.com

Please inform patients to complete on-line registration forms 48 hours prior to scheduled appointment to expedite process upon arriving to our office(s).