
# CONSULTATION / REFERRAL REQUEST

**Please complete and fax to our Scheduling Department at (352) 336-6071.**
The Patient will be contacted within 24 hours of fax receipt to schedule their appointment.
You will be notified of their appointment date, time and location by return fax.

If you prefer to schedule an appointment directly, please call our Scheduling Department at (352) 336-6032.
**Thank you.**

Provider Requesting Consultation / Referral_____

Office Telephone #_____ Fax #_____

Contact Person_____

Preferred TOI Physician (from list at left)_____
Or
First Available Specialist (check one) ☐ General ☐ Hand ☐ Foot/Ankle
☐ Spine ☐ Shoulder ☐ Plastics

Reason for referral_____

Patient Name_____

Patient Address_____

Date of Birth_____ Social Security #_____

Patient Diagnosis_____

Insurance Carrier_____

Insurance ID#_____

Patient Telephone # (Work)_____ (Home)_____

**(To be completed by The Orthopaedic Institute and returned via fax to referring physician's office)**

The following appointment has been scheduled with Dr. _____

Date_____ Time_____

Office Location_____