



Northeast Orthopedic Sports
Clinic & Physical Therapy

Physician FAX Referral Form

NORTHEAST ORTHOPEDICS

PHONE (256) 547-7417

FAX (256) 547-7414

LOCATIONS:

- ☐ Rainbow City ☐ Jacksonville
☐ Fort Payne ☐ Boaz
☐ Gadsden ☐ Center Location

Referring Physician: _____

Contact Person: _____

Physician Phone: _____ Fax Number: _____

Patient Name: _____ Email: _____

Date Of Birth: _____ Address: _____

City/State/Zip: _____

*Patient Phone #: _____ Alternate #: _____

Gender (please check): ☐ Female ☐ Male *Insurance: _____

* REQUIRED information to schedule Patient

Where is the pain? (Please check all that apply)

- ☐ Neck ☐ Upper Back ☐ Elbow ☐ Shoulder ☐ Lower Back ☐ Hand ☐ Ankle
☐ Hip ☐ Arm ☐ Knee ☐ Other

Was patient involved in a motor vehicle accident? ☐ No ☐ Yes If Yes, Date : _____

Previous Studies: ☐ X-Ray ☐ Myelogram ☐ CT Scab ☐ MRI ☐ Bone Scan ☐ EMG/NCS

Facility Name: _____

*If previous studies exist, please bring disk & copy of report(s) to aid in patient evaluation.

Evaluation/Treatment: _____

DX/Comments :