



MOORE ORTHOPAEDIC CLINIC – REFERRAL FORM

First Name: _____ MI ____ Last Name: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Hm Ph#(_____) _____

Wk Ph#(_____) _____

Cell#(_____) _____

DOB: ___/___/___ SSN: _____ Gender (circle): Male / Female

DOI: ___/___/___ BODY PART(S): _____ (indicate Left or Right if appropriate)

Referring Physicians Name: _____ Phone #: _____

Referring Physician NPI# _____

Request Sent By: _____ Fax #: _____

Has patient had x-rays? **Yes** or **No** (Please make sure patient is aware these are required at appt)

Has patient been treated by another orthopaedist for this problem? **Yes** or **No**

If you are requesting a specific Moore Clinic Physician please indicate who: _____

Ins. Carrier Name: _____ Id # _____

Policy Holder's Name _____ DOB _____ SSN _____

Note: If child, Guardian Name _____ DOB _____ SSN _____

Telephone @ to Verify Benefits: (_____) _____ Group # _____

(please attach a copy of the front and back of insurance card with this fax)

Is this is a Workers Comp injury? **Yes** or **No** (If yes- we cannot file private insurance!)

Please fax your request to: Moore Clinic Appointment Staff @ 227-8015

Any request received by 4:00 pm M-F will be processed by 5:00 pm that day. Any request received after hours will be processed by 9:00 am the following business day. Patients will be contacted at the number provided above with their appointment date & time! A copy of this completed fax request will be faxed back to your office upon completion.

If you have any questions or concerns with your referral process – please contact Appointments at (803)227-8000

Rev 10/08

MOC OFFICE Completed by: _____ Date: _____ Patient Contacted: _____

USE ONLY: Appt Date: _____ Time: _____ Dr. _____