



MIDLANDS ORTHOPAEDICS, P.A.

Emergency Appointment Request Fax Form

FAX (803) 251-5220 – TRIAGE DEPARTMENT

TODAY'S DATE _____ REFERRING PHYSICIAN _____

REFERRING PHYSICIAN CONTACT NAME _____ PHONE # _____

PATIENT'S NAME _____ DOB _____ MALE FEMALE

PATIENT'S DAYTIME PHONE # _____

NAME AND PHONE NUMBER OF PERSON YOU WANT NOTIFIED OF THIS APPOINTMENT (IF NOT PT)

NAME: _____ PHONE #: _____

MIDLANDS ORTHOPAEDICS OFFICE LOCATION TO WHICH THE PATIENT IS CLOSEST:

BLANDING WEST COLUMBIA IRMO

REASON FOR REFERRAL (LIST BODY PARTS EFFECTED) _____

NATURE OF PROBLEM _____

HOW INJURY OCCURRED _____

WHEN INJURY OCCURRED (IF ACUTE) OR SYMPTOMS BEGAN (IF CRONIC) _____

REFERRING PHYSICIAN REQUESTING CONSULT? _____ YES _____ NO

IF FRACTURE: DISPLACED NON-DISPLACED

IS PATIENT DIABETIC? YES NO

NAME OF PATIENT'S INSURANCE COMPANY? _____

IF THIS IS A WORKER'S COMP INJURY, PLEASE COMPLETE THE FOLLOWING:

EMPLOYER NAME: _____ PHONE #: _____

NAME OF CONTACT AT WORK WHO CAN VERIFY WORKER'S COMP: _____

FOR OFFICE USE ONLY:

Time rec'd: _____ By whom: _____ Time call ret'd: _____ Prev MOPA MD: _____

Is pt ambulatory? _____ Transport via EMS? _____ Disposition of call: _____