

TOC Physician FAX Referral Form

Please Fax to: (256) 705-3199

Schedule Appointment with: (Please check preferred physician or leave open for first available)

ORTHOPAEDIC SURGEONS

- | | | |
|--|--|--|
| <input type="checkbox"/> Ginger K. Bryant , M.D. | <input type="checkbox"/> Steven L. Buckley , M.D. | <input type="checkbox"/> Richard C. Burnside , M.D. |
| <input type="checkbox"/> Michael W. Cantrell , M.D. | <input type="checkbox"/> Joseph W. Clark , M.D. | <input type="checkbox"/> Stanton B. Davis , M.D. |
| <input type="checkbox"/> Matthew DeOrio , M.D. | <input type="checkbox"/> Ray A. Fambrough , M.D. | <input type="checkbox"/> W. Allen Goodson , M.D. |
| <input type="checkbox"/> John J. Greco , M.D. | <input type="checkbox"/> David B. Griffin , M.D. | <input type="checkbox"/> Louis G. Horn III , M.D. |
| <input type="checkbox"/> Michael G. Lawley , M.D. | <input type="checkbox"/> Mark A. Leberte , M.D. | <input type="checkbox"/> Philip A. Maddox , M.D. |
| <input type="checkbox"/> R. Allan Maples , M.D. | <input type="checkbox"/> Jeffrey W. McKee , D.P.M. | <input type="checkbox"/> Howard G. Miller , M.D. |
| <input type="checkbox"/> Michael E. Miller , M.D. | <input type="checkbox"/> Thomas J. Thomasson , M.D. | |



Highly skilled specialists...
world class care

SPINE SURGEONS

- | | | |
|--|--|--|
| <input type="checkbox"/> Gilbert M. Aust , M.D. | <input type="checkbox"/> Cyrus Ghavam , M.D. | <input type="checkbox"/> Larry M. Parker , M.D. |
| <input type="checkbox"/> F. Calame Sammons , M.D. | <input type="checkbox"/> Brian M. Scholl , M.D. | <input type="checkbox"/> Morris B. Seymour , M.D. |

PHYSICAL MEDICINE & REHABILITATION

- | | |
|--|---|
| <input type="checkbox"/> Brian R. Carter , M.D. | <input type="checkbox"/> Craig E. Lincoln , M.D. |
| <input type="checkbox"/> Vandana M. Maladkar , M.D. | <input type="checkbox"/> Sara Nadella , M.D. |



Is this a (please check): New Patient Existing Patient with new problem Existing Patient with old problem

Location: First Available Decatur Clinic Fayetteville Clinic Guntersville Clinic
 Huntsville Main Clinic Huntsville Crestwood Clinic Madison Clinic Scottsboro Clinic

Referring Physician: _____ Contact Person: _____

Telephone Number: _____ Fax Number: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Telephone Number: _____ Alt. Telephone Number: _____

Gender (please check): Female Male SS#: _____

Insurance: _____

Diagnosis: _____

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

- | | | | |
|-----------------------------------|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Acute | <input type="checkbox"/> Neurological Deficit |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other: (Please specify) |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other: (Please specify) |

Duration of complaints: _____

Was the patient involved in a moving vehicle accident? No Yes If Yes, Date: _____

Previous Surgeries: (please list)

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

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

*For Appointments with Drs. Carter, Lincoln and Maladkar only:

EMG (please specify extremity): _____

Evaluation/Treatment: _____

Requested Appointment Day: Monday Tuesday Wednesday Thursday Friday

Requested Time: AM PM (Leave open for first available appointment)