TOC The Orthopaedic Center
ORTHOPAEDICS, SPINE & SPORTS MEDICINE
World-Class Expertise. Exceptional Care.

# TOC Physician FAX Referral Form

Please fax to preferred location

## ATHENS PHYSICIANS

### FAX TO 256.704.6202

**PHONE 256.233.2332**

#### ORTHOPAEDIC SURGEONS

☐ Patrick **Boyett**, DO
☐ Eric **Stanford**, DO
☐ William **Lawrence**, DO

#### ORTHO NON-SURGICAL

☐ Jason **Hatfield**, DO
☐ Shane **Palmer**, PA (Florence Only)

#### FOOT / ANKLE

☐ Jason **Hatfield**, DO
☐ David **Kyle**, DPM

#### SPINE SURGEONS

☐ Blake **Boyett**, DO

#### SPINE NON-SURGICAL

☐ Hunter **Boyett**, DO
☐ Jason **Hatfield**, DO

☐ **FIRST AVAILABLE**

## HUNTSVILLE PHYSICIANS

### FAX TO 256.705.3199

**PHONE 256.539.2728**

#### ORTHOPAEDIC SURGEONS

☐ Michael **Cantrell**, MD
☐ Stanton **Davis**, MD
☐ John **Greco**, MD
☐ David **Griffin**, MD
☐ James **Hughey**, III DO
☐ William **Lawrence**, DO
☐ Mark **Leberte**, MD
☐ Su **Madanagopal**, MD
☐ Allan **Maples**, MD
☐ Christopher **Parks**, MD
☐ Matthew **Smith**, DO (Guntersville/Boaz)
☐ Thomas **Thomasson**, MD
☐ Bradley **Wills**, MD

#### HAND / WRIST / ELBOW

☐ Joseph **Clark**, MD
☐ Heather **Licht**, MD
☐ Philip **Maddox**, MD

#### PEDIATRIC

☐ Steven **Buckley**, MD
☐ Michael **Lawley**, MD

#### SPINE SURGEONS

☐ Larry **Parker**, MD
☐ John **Rodriguez-Feo**, MD
☐ Brian **Scholl**, MD
☐ Morris **Seymour**, MD
☐ Murray **Spruiell**, MD

#### SPINE NON-SURGICAL

☐ Brian **Carter**, MD
☐ Michael **Cosgrove**, MD
☐ Craig **Lincoln**, MD
☐ Sara **Nadella**, MD

#### PAIN MANAGEMENT

☐ Michael **Cosgrove**, MD

#### FOOT / ANKLE

☐ Matthew **DeOrio**, MD
☐ David **Kyle**, DPM
☐ Bradley **Sabatini**, MD

☐ **FIRST AVAILABLE**

Location:
☐ **Ardmore**
☐ **Athens**
☐ **Florence**
☐ **Rogersville**
☐ **Winfield**

Location:
☐ **Boaz**
☐ **Crestwood**
☐ **Decatur**
☐ **Fayetteville**
☐ **Guntersville**
☐ **Huntsville Main**
☐ **Madison**
☐ **Scottsboro**

Referring Physician: _____ Contact Person: _____

Physician Phone #: _____ Fax Number: _____

*Patient Name: _____ *Date of Birth: _____

*Address: _____ City/State/Zip: _____

Email: _____ *Patient Phone #: _____

Gender (please check): ☐ Female ☐ Male _____ Alternate Phone #: _____

*Insurance: _____ * REQUIRED information to schedule Patient

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

☐ Neck ☐ Upper Back ☐ Elbow ☐ Foot
☐ Shoulder ☐ Lower Back ☐ Hand ☐ Ankle
☐ Hip ☐ Arm ☐ Knee ☐ Other: (Please specify) _____

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

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.

Evaluation/Treatment: _____

**DX/Comments**