TOC The Orthopaedic Center

ORTHOPAEDICS, SPINE & SPORTS MEDICINE

World-Class Expertise. Exceptional Care.

TOC Physician FAX Referral Form

Please fax to **256.263.1347**

FLORENCE PHYSICIANS

FAX TO 256.263.1347

PHONE 256.263.1015

ORTHOPAEDIC SURGEONS

☐ William **Lawrence**, DO

SPINE SURGEONS

☐ Blake **Boyett**, DO

☐ Murray **Spruiell**, MD

☐ Shane **Palmer**, PA
Collaborating with Florence Physicians

☐ **FIRST AVAILABLE**

☐ **OTHER** ________________________________

DX/Comments

Referring Physician: ____

Contact Person: ____

Physician Phone #: ____

Fax Number: ____

*Patient Name: ____

*Date of Birth: ____

*Address: ____

City/State/Zip: ____

Email: ____

*Patient Phone #: ____

Alternate Phone #: ____

Gender (please check): ☐ Female ☐ Male ________________________

*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: ______________

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

Facility Name: ____

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

Evaluation/Treatment: ____