Austin County Orthopedics

A Direct Specialty Care Clinic

Dr. Shawn E. Johnson M.D.

AUSTIN COUNTY ORTHOPEDICS REFERRAL FORM

TO: AUSTIN COUNTY ORTHOPEDICS
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FROM: REFERRING PROVIDER/FACILITY:_____
PHONE:_____ FAX:_____
EMAIL: _____

PATIENT NAME:_____

PATIENT DOB:_____ PHONE NUMBER:(H)_____(M)_____

EMAIL ADDRESS:_____

PRIMARY ORTHOPEDIC COMPLAINT: _____(R)___(L)___(BOTH)___

HAS THE PATIENT HAD RECENT X-RAY OR OTHER DIAGNOSTIC STUDIES? (Y)_____ (N)_____

WHERE WERE THE STUDIES PERFORMED?_____

DOES THE PATIENT HAVE THE STUDIES READILY AVAILABLE TO VIEW? (Y)_____ (N)_____

DOES THE PATIENT HAVE THE REPORTS FOR THE STUDIES? (Y)_____ (N)_____

IS THE PATIENT INTERESTED IN:
_____DIRECT CARE MODEL FOR ORTHOPEDIC TREATMENT?

_____TRADITIONAL INSURANCE MODEL FOR ORTHOPEDIC TREATMENT?
IF INTERESTED IN THE DIRECT CARE MODEL, WHERE WOULD THE PATIENT LIKE TO BE SEEN?
_____

PLEASE INFORM THE PATIENT THAT THEY WILL BE CONTACTED VIA EMAIL OR PHONE TO DETERMINE THE NEXT STEPS IN THEIR ORTHOPEDIC CARE.

FOR ANY QUESTIONS PLEASE VISIT
drshawnmdortho.com