

Scheduling: 928.226.2900, Opt 2 | Referral Fax: 928.226.3070
 STAT Referral Fax: 928.226.3080

- Step 1:** Fax this form, along with the patient's referral (if applicable) to fax number above.
Step 2: A Referral Coordinator will contact the patient within 24 hours to schedule an appointment with the appropriate provider.
Step 3: You will receive a confirmation of your patients' appointment status or if we were unable to reach the patient.

YOUR INFORMATION

Referring Provider: _____ NPI Number: _____
 Contact Name: _____ Phone #: _____

VISIT INFORMATION (CHECK ONE IN EACH CATEGORY)

SPECIALTY REQUESTED	AREA REQUESTED	TIME REQUESTED	VISIT TYPE
<input type="checkbox"/> Adult Joint Reconstructive	<input type="checkbox"/> Flagstaff (F)	<input type="checkbox"/> <48 hours	<input type="checkbox"/> New
<input type="checkbox"/> Orthopaedic Spine	<input type="checkbox"/> Prescott Valley (PV)	<input type="checkbox"/> First Available	<input type="checkbox"/> Follow-Up
<input type="checkbox"/> Interventional Spine/Pain/PMR	<input type="checkbox"/> Lakeside/Show Low (L)	<input type="checkbox"/> Less Than One Week	<input type="checkbox"/> EMG
<input type="checkbox"/> Sports Medicine		<input type="checkbox"/> Patient's Convenience	<input type="checkbox"/> Workers' Comp
<input type="checkbox"/> Hand and Upper Extremity			<input type="checkbox"/> Liability
<input type="checkbox"/> Foot and Ankle			<input type="checkbox"/> Date of Injury: _____

PROVIDERS AND LOCATIONS

- | | |
|--|--|
| <input type="checkbox"/> Bourck Cashmore, MD (F, PV) | <input type="checkbox"/> Blake Obrock, DO (F, PV) |
| <input type="checkbox"/> John Ledington, MD (F) | <input type="checkbox"/> Hayden Poulson, DPM (F, PV) |
| <input type="checkbox"/> Yuri Lewicky, MD (F, PV) | <input type="checkbox"/> Stephen Ros, MD (F, PV) |
| <input type="checkbox"/> Eamonn Mahoney, MD (F, PV, L) | <input type="checkbox"/> Jamie Pearson, PA-C (PV) |
| <input type="checkbox"/> Mark Mellinger, MD (F, PV, L) | |

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Phone: (H) _____ (Cell) _____ (Work) _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Guardian Name (if applicable): _____ DOB: _____

Reason for Visit/Diagnosis: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____
Primary Ins. Address _____ Or P.O. Box: _____
 Secondary Insurance: _____ ID #: _____
 Cardholder's Name: _____ DOB: _____

Please refer to the insurance guide to determine if the patient requires a referral; if a referral is required, please note we will need to receive the referral from your office prior to seeing the patient.

When sending the referral, please include the approved number of visits and valid date range (i.e. 90 days)