Northern Arizona ORTHOPAEDICS
Outcomes by HOPCo

NAO REFERRAL FORM

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
- ☐ Adult Joint Reconstructive
- ☐ Orthopaedic Spine
- ☐ Interventional Spine/Pain/PMR
- ☐ Sports Medicine
- ☐ Hand and Upper Extremity
- ☐ Foot and Ankle

AREA REQUESTED
- ☐ Flagstaff **(F)**
- ☐ Prescott Valley **(PV)**
- ☐ Lakeside/Show Low **(L)**

TIME REQUESTED
- ☐ <48 hours
- ☐ First Available
- ☐ Less Than One Week
- ☐ Patient's Convenience

VISIT TYPE
- ☐ New
- ☐ Follow-Up
- ☐ EMG
- ☐ Workers' Comp
- ☐ Liability
- ☐ Date of Injury: _____

PROVIDERS AND LOCATIONS

- ☐ Bourck Cashmore,MD **(F, PV)**
- ☐ John Ledington, MD **(F)**
- ☐ Yuri Lewicky, MD **(F, PV)**
- ☐ Eamonn Mahoney, MD **(F, PV, L)**
- ☐ Mark Mellinger , MD **(F, PV, L)**
- ☐ Blake Obrock, DO **(F, PV)**
- ☐ Hayden Poulson, DPM **(F, PV)**
- ☐ Stephen Ros, MD **(F, PV)**
- ☐ Jamie Pearson, PA-C **(PV)**

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)

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