Workers' Compensation Referral Form

****** When referring a patient to Triangle Orthopaedics, please complete the following referral form and fax to 919-281-1799 Attn: Workers Comp Dept. or email to WorkersComp@EmergeOrtho.com*****

Patient's Name: ______

Social Security Number: ______ **Date of Birth:** ______

Home Address: ______ **Zip Code:** ______

Phone: ______ **Alternate Phone:** ______

Patient's Email Address: ______

How did you hear about Triangle: ______

Employer: ______

Employer Address: ______

Contact: ______

Phone: ______ **Fax:** ______

Worker's Compensation Insurance: ______

Billing address for insurance: ______

WC insurance adjuster: ______ **Phone#** ______

Adjuster Fax#: ______ **Email:** ______

Case manager name: ______ **Phone:** ______

Fax # ______ **Email:** ______

Who authorized Treatment to EmergeOrtho? ______ **Phone:** ______

Preferred Location to Treat: ______ **Preferred Provider:** ______

Date of Injury: ______ **Injured Body Part(s):** ______

Claim Number: ______ **State of WC Claim:** ______

Has the patient received any prior treatment? (ER, Urgent Care, Orthopedist, Neurologist, Surgery, etc.)

______

CD OF ANY X-RAYS OR MRI'S MUST COME WITH PATIENT TO APPT.

PLEASE FAX ALL MEDICAL RECORDS TO 919-281-1799

Referring Doctor/Clinic: ______
Phone/Fax: ______

****INCOMPLETE INFORMATION WILL DELAY PATIENT SCHEDULING****