Kentucky Orthopedics & Sports Medicine

Thank you in advance for giving us the opportunity to care for your patient. Please complete the following info and fax to our attention.

PHONE: 502-834-5676
FAX: 833-700-1693

REFERRAL

Today's Date:______________________________ Patient Name: ______________________________

Referring Provider:______________________________ Patient Cell #: ______________________________

Referring Provider Phone:______________________________ Patient Home #:______________________________

Referring Provider Fax:______________________________ Patient DOB: ______________________________

WE ACCEPT ALL MAJOR MEDICAL INSURANCES;
INCLUDING MEDICARE, MEDICAID AND WORKER'S COMPENSATION

AUTHORIZATION

❑ Evaluate and Treat as Appropriate

❑ Special and/or Specific Procedure:______________________________

REASON FOR VISIT

____

____

PREVIOUS PAIN MANAGEMENT? Y / N PROVIDER:______________________________

PREVIOUS CONSERVATIVE THERAPY? Y / N PROVIDER:______________________________

THE FOLLOWING DOCUMENTATION MUST BE ATTACHED

1. OFFICE NOTES
2. PATIENT DEMOGRAPHICS (MUST INCL. SSN, ADDRESS)
3. IMAGING
4. **COPY OF INSURANCE CARD(S)**

Our staff is unable to schedule without the above.