

Patient Name _____ Date of Birth _____ Social Security # _____ Address _____ City _____ State _____ Zip _____ Telephone # _____ Primary Insurance _____ Primary Policy # _____ Group # _____ Secondary Insurance _____ Secondary Policy # _____ Group # _____	Ordering Physician Signature _____ Ordering Physician (Print) _____ Primary Care Physician _____ Send Copy to _____ Fax Results to _____ Diagnosis #1 _____ ICD-10 Code _____ Diagnosis #2 _____ ICD-10 Code _____ Diagnosis #3 _____ ICD-10 Code _____ Diagnosis #4 _____ ICD-10 Code _____
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Request for Opinion

Consult Request to: _____

A request for opinion and consult for the above-named patient is being sent to Goshen Orthopedics and Sports Medicine for the following reasons:

The physician requesting this opinion understands that the consulting physician may initiate treatment or perform medically necessary diagnostics for this patient. The consulting physician will send the requesting physician an opinion and plan of care.

Appointment Date (completed by Ortho PSR): _____

Confirmation fax sent to requesting physician: Today's date _____

****Please sign and return by fax to 574-534-3622****

Attending Physician Signature: _____ Date: _____
(Signature of attending physician or representative)

Attending Physician: _____
(Please print)

1824 Dorchester Court, Suite A, Goshen IN 46526
 Ph. 574.534.2548 Fax 574.534.3622

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