



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

Request for Opinion

Consult Request to: _____

A request for opinion and consult for the above-named patient is being sent to Goshen Orthopedics 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.

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

This portion to be completed by Goshen Orthopedics

Appointment Date: _____

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

Attending Physician: _____
(Please print)

1824 Dorchester Ct., Suite A, Goshen, IN 46526
Ph. (574) 534-2548 | Fax (574) 534-3622

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