NORTHWEST
ORTHOPAEDIC
SPECIALISTS

Delivering Excellence

Refer A Patient

Thank you for entrusting Northwest Orthopaedic Specialists with your patients. Please fill out the form below and fax it to 509-624-9179. We will contact your patient directly to schedule an appointment within 24 hours.

Section 1: Patient Information (REQUIRED)

Name ______________________________ Home ______________________________

Address ______________________________ Work ______________________________

City ______________ State _____ Zip _________ Cell ______________________________

Date of Birth ______________________________ E-Mail ______________________________

Gender ☐ M ☐ F

Insurance ____

Symptoms & Diagnosis ____

____

Was this injury/condition related to Workers' Compensation? ☐ No ☐ Yes

Patient has completed: ☐ Bone Scan ☐ CT Scan ☐ MRI ☐ EMG ☐ X-Rays ☐ Cast/Splint Applied

Does the patient have a request for a certain doctor? ☐ No ☐ Yes, ______________________________

Section 2: Referring Physician Contact Information (REQUIRED)

Referring Physician ______________________________ Contact Name ______________________________

Phone Number ______________________________ E-Mail ______________________________

Fax Number ______________________________