



Physician Referral Form

Fax Referrals to: (317) 872-6865

REFERRING PHYSICIAN INFORMATION

Date: _____ Contact Person Name: _____
 Referring Office (Practice Name): _____ Contact Phone #: _____
 Referring MD: _____ Fax Phone #: _____

PATIENT INFORMATION

Patient Name: _____ Home Phone #: _____
 Date of Birth: _____ Alternate Phone #: _____
 Insurance Company: _____ Policy #: _____
 Policy Holder Name: _____ Policy Type/Name: _____
 Diagnosis/Symptoms: _____ Injured Body Part Hand Wrist Elbow Shoulder

Prior Testing/Surgery for this problem:

X-ray MRI CT EMG
 Fluoroscopy Angiogram Other: _____

Patient face sheet or demographic form is appreciated but not required.

Indiana Hand to Shoulder Center Physician Requested:

William Kleinman, MD James Creighton, MD Jeffrey Greenberg, MD Kevin Knox, MD
 Hill Hastings, MD Alexander Mih, MD F. Thomas Kaplan, MD First Available
 Thomas Fischer, MD Robert Baltera, MD Gregory Merrell, MD

Preferred Location:

Avon Indianapolis-Downtown Kokomo Terre Haute
 Fishers Indianapolis-Northside Lafayette

INDIANA HAND TO SHOULDER CENTER CONTACT INFORMATION (All Locations)

Referral Coordinator: Diane Lawler Contact Phone #: (317) 870-5207
 Referral Coordinator (back up): Jessica Parrott Contact Phone #: (317) 870-5213

Please call our Referral Coordinator with any concerns or questions regarding the referral process.

FOR INDIANA HAND TO SHOULDER CENTER USE ONLY:

(form will be faxed back to referring physician once appointment is scheduled)

Appointment Date: _____ Appointment Time: _____
 Physician: _____ Location: _____

WE ACCEPT THE FOLLOWING INSURANCE CARRIERS:

- Advantage (SIHO, Suburban Health, St V CMO)
- Aetna
- Anthem
- Anthem/HIP
- Humana/Choice Care
- IU Health Plan/Healthsmart
- Cigna
- Encore
- Indiana Health Network
- Medicare
- Multiplan
- Ohio Bureau of Workers' Comp
- Sagamore
- Tricare
- United Healthcare