



Physician Referral Form

Fax Non Urgent Referrals to: (317) 872-6865

For URGENT appt requests (within 1-3 days), please call the office at 317-875-9105 x 360

REFERRING PHYSICIAN INFORMATION

Date: _____ Contact Person Name: _____
 Referring Office: _____ Contact Phone #: _____
 (Practice Name)
 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 Jeffrey Greenberg, MD Nicholas Crosby, MD Brandon Smetana, MD
 Thomas Fischer, MD F. Thomas Kaplan, MD Kathryn Peck, MD Sameer Puri, MD
 Robert Baltera, MD Gregory Merrell, MD Reed Hoyer, MD First Available

Indiana Hand to Shoulder Center Location Requested:

- Avon Indianapolis-Northside Kokomo Terre Haute
 Fishers Westfield Lafayette Indianapolis-Southside
 Rushville Greenfield

INDIANA HAND TO SHOULDER CENTER CONTACT INFORMATION (All Locations)

Referral Coordinator: _____ Diane Lawler _____ Contact Phone #: _____ 317-471-4309 _____

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: _____