optimorthopedics

Dr. George Sutherland Patient Referral Patient Form

☐ CHECK THIS BOX FOR STAT REFERRAL PLEASE

OKATIE
16 Okatie Center Blvd, South,
Suite 201, Okatie, SC 29909
p: 843.705.9401
f: 843.705.9403

BEAUFORT
95 Sea Island Pkwy, Suite 102
Beaufort, SC 29907
p: 843.705.9401
f: 843.705.9403

Referring Practice Information:

Referring Physician ______________________________

Practice Name ______________________________

Office Phone ________________ Office Fax ________________

Contact Person ______________________________

Patient Information:

Name (first/middle/last) ______________________________

Address ______________________________

City/State/Zip ______________________________

Phone ________________ Other ________________

Date of Birth ________________ Circle one: Male / Female

Social Security # ________________

Appointment Info

Date: ________________

Time: __________ ☐ a.m. ☐ p.m.

Physician: ________________

Appt. location: ________________

Optim employee initials: _____

Insurance Information: *Fax copies of the insurance cards. If card is attached, skip section.*

Primary Insurance ______________________________ Referral # (if required): ____________

Policy # ______________________________

Insurance Carrier: ☐ Patient ☐ Spouse Other ________________

Secondary Insurance ______________________________ Referral # (if required): ____________

Policy # ______________________________

Insurance Carrier: ☐ Patient ☐ Spouse Other ________________

Patient History:

Relevant History ______________________________

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Reason for Referral ______________________________

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PLEASE FAX THIS FORM TO **843.705.9403**

Please instruct your patient to bring X-Ray disc, MRI disc and read, and any diagnostic tests to their appointment.
Please include patient medical history, family history and recent medications when sending the referral.

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