

**TOC Physician
 FAX Referral Form**
Please Fax to: (256) 705-3199

Schedule Appointment with: (Please check preferred physician or first available)

ORTHOPAEDIC SURGEONS

- | | | |
|---|---|--|
| <input type="checkbox"/> Patrick Boyett , DO | <input type="checkbox"/> James Hughey , III DO | <input type="checkbox"/> Allan Maples , MD |
| <input type="checkbox"/> Steven Buckley , MD | <input type="checkbox"/> Michael Lawley , MD | <input type="checkbox"/> Howard Miller , MD |
| <input type="checkbox"/> Michael Cantrell , MD | <input type="checkbox"/> William Lawrence , DO | <input type="checkbox"/> Christopher Parks , MD |
| <input type="checkbox"/> Joseph Clark , MD | <input type="checkbox"/> Mark Leberte , MD | <input type="checkbox"/> Matthew Smith , DO |
| <input type="checkbox"/> Stanton Davis , MD | <input type="checkbox"/> Heather Licht , MD | <input type="checkbox"/> Eric Stanford , DO |
| <input type="checkbox"/> John Greco , MD | <input type="checkbox"/> Su Madanagopal , MD | <input type="checkbox"/> Thomas Thomasson , MD |
| <input type="checkbox"/> David Griffin , MD | <input type="checkbox"/> Philip Maddox , MD | <input type="checkbox"/> Bradley Wills , MD |

ORTHO NON-SURGICAL

- Jason **Hatfield**, DO
 Michael **Miller**, MD
 Shane **Palmer**, PA

FOOT & ANKLE

- Matthew **DeOrio**, MD
 David **Kyle**, DPM
 Bradley **Sabatini**, MD

SPINE SURGEONS

- Blake **Boyett**, DO
 Larry **Parker**, MD
 John **Rodriguez-Feo**, MD
 Brian **Scholl**, MD
 Morris **Seymour**, MD
 Murray **Spruiell**, MD

SPINE NON-SURGICAL

- Hunter **Boyett**, DO
 Brian **Carter**, MD
 Michael **Cosgrove**, MD
 Jason **Hatfield**, DO
 Craig **Lincoln**, MD
 Vandana **Maladkar**, MD
 Sara **Nadella**, MD

PAIN MANAGEMENT

- Michael **Cosgrove**, MD

Is this a (please check): New Patient Existing Patient with a new problem Existing Patient with an old problem

Location: **First Available** **Huntsville Main** **Ardmore** **Athens** **Boaz** **Decatur** **Fayetteville**
 Florence **Guntersville** **Huntsville South** **Madison** **Rogersville** **Scottsboro** **Winfield**

Referring Physician: _____

Physician Phone #: _____

Patient Name: _____

Address: _____

Email: _____

Gender (please check): Female Male

Insurance: _____

Contact Person: _____

Fax Number: _____

Date of Birth: _____

City/State/Zip: _____

Patient Phone #: _____

Alternate Phone #: _____

Where is the pain? (Please check all that apply)

- | | | | |
|-----------------------------------|-------------------------------------|--------------------------------|--|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Upper Back | <input type="checkbox"/> Elbow | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Lower Back | <input type="checkbox"/> Hand | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Arm | <input type="checkbox"/> Knee | <input type="checkbox"/> Other: (Please specify) _____ |

Was patient involved in a motor vehicle accident? No Yes If Yes, Date: _____

Previous Studies: X-Ray Myelogram CT Scan MRI Bone Scan EMG/NCS

*If previous studies exist, please bring films & copy of report(s) to aid in patient evaluation.

*For the following Appointments with Drs. Maladkar and Nadella only:

EMG/NCS (please specify extremity): _____

Evaluation/Treatment: _____

DX/Comments

FOR TOC USE ONLY

Appointment Comments: _____