CAROLINA BONE & JOINT
ORTHOPEDICS RHEUMATOLOGY PAIN MANAGEMENT

Workers Compensation Referral Form
Fax# 704-220-1004
Or via e-mail: kgault@bonesrus.org

1. Patient Information:

Patient Name: _____ Date of Injury: _____

Patient Mailing Address: _____ City/State/Zip: _____

Patient Telephone: _____ DOB:_____

Soc Sec#:_____ Referred by:_____

Employer: _____

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2. Patient Intake Questionnaire (please check)

1. **Is your treatment covered by worker's compensation -** ☐ Yes ☐ No

(**If yes, Carrier Name**: _____ Billing Address: _____

Claim#:_____ Adjuster:_____

Ph#: _____ Fax#_____ Email: _____

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3. Present Complaints/Body Part Approved to treat:

_____

Is this a: One time Eval? ☐ Yes ☐ No Eval & treat: ☐ Yes ☐ No

Did you go to the Hospital? ☐ Yes or ☐ NO (If Yes, where?)_____

Have you received any other medical care? ☐ Yes or ☐ NO (If so, Name & Ph#: of other doctor's)

Location Requested: (circle one) ☐ **Monroe, NC** ☐ **Pineville, NC** ☐ **Greensboro, NC** ☐ **Columbia, SC**

Appointment Scheduled: **Date:** _____ **Time:** _____
