



Experts in Orthopedic Care

3334 CAPITAL MEDICAL BLVD | 2605 WELAUNEE BLVD

PHONE: 850.877-8174 FAX: 844.261.6839

TEAMTOC.com

CONSULTATION REQUEST

Patient's Name: _____

Date of Birth: _____ SS#: _____

Address: _____

Home Ph #: _____ Work Ph #: _____ Cell #: _____

Medical Reason for Appointment: _____

Has patient had x-rays, MRI, etc.? Yes or No

(Patient must bring x-rays, MRI, etc. with them to the appointment)

Was patient involved in an accident or injury? Yes or No _____MVA _____W/Comp_____Other

If "Yes", Date of Injury/Accident: _____

***** Please advise patient that any copay/co-insurance is due at the time services are rendered*****

Insurance Primary: _____ Secondary: _____

*****Patient must bring insurance card(s) and a picture I.D. at the time of the appointment*****

Physician Requesting Consult: _____

Office Phone #: _____ Office Fax #: _____

I am requesting that Tallahassee Orthopedic Clinic or its affiliated satellite office performs a consultation on the above referenced patient for the medical problem indicated.

Physician's Signature

Date

*Providing the highest quality, patient-centered orthopedic care
and sports medicine to North Florida and South Georgia.*

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