

**ORTHOPEDIC, PODIATRY & PAIN MANAGEMENT REFERRALS**

**PHONE: 717.761.5530 ext. 8 (DR. LINE ONLY – Not for patients)**

**APPOINTMENT REQUEST/REFERRAL FAX: 717.901.4247**

**Direct Messaging: practice@oip.com**

**MRI REFERRALS**

**PHONE: 717.980.3710 | FAX: 717.920.1846**

**Direct Messaging: practice@oip.com**

**PHYSICAL THERAPY REFERRALS**

**CAMP HILL 717.920.2620 | FAX: 717.920.2621 CARLISLE 717.980.3568 | FAX: 717.826.0839**

**HARRISBURG 717.920.4950 | FAX: 717.920.4955 HERSHEY 717.483.2311 |FAX: 717.925.8941**

**MILLERSBURG 717.889.7321 | FAX: 717.207.7321**

**PLEASE CALL THE OFFICE TO SCHEDULE FRACTURE AND SAME DAY APPOINTMENTS**

**Referring Provider Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider Fax #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider NPI:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Last First M.I.**

**Patient DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Email (if known):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a minor, please list parent/guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Appointment (Please circle)**

Orthopedic Podiatry Pain Management

MRI (fax to 717.920.1846 – MUST INCLUDE ORDER)

Physical Therapy (fax to the PT office fax number above – MUST INCLUDE PT SCRIPT)

**Will this patient need an interpreter or translator? (Circle One):**

No Yes: Sign Language Yes: Language (primary language) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list if you are requesting a specific provider/location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE ATTACH PATIENT DEMOGRAPHICS, INSURANCE CARD, MOST RECENT OFFICE NOTE AND TEST RESULTS**