



**Methodist
Sports Medicine**
THE ORTHOPEDIC SPECIALISTS

Referral Form - All Locations

Patient Name: _____ DOB: _____

Male	Female
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Address: _____ Insurance: _____

_____ ID #: _____

Contact Phone: _____ Insured Name: _____

_____ Insured DOB: _____

****Please include copy of Insurance Card with Fax****

Requested Location:

- North⁺ - 201 Pennsylvania Parkway, Suite 100, Indianapolis, IN 46280
- South⁺ - 1401 West County Line Rd, Greenwood, IN 46142
- West - 1115 North Ronald Reagan Parkway, Suite 148, Avon, IN 46123 **(Snead Only)**
- Tipton[~] - 1010 South Main Street, Suite 100, Tipton, IN 46072
- Bloomington - 639 South Walker Street, Suite E, Bloomington, IN 47403

Requested Physician:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alvey ⁺ (Sports Med/Triage) | <input type="checkbox"/> Marratt ^{**} (Total Hip/Knee) | <input type="checkbox"/> Sallay ⁺ (Shoulders/Knee) |
| <input type="checkbox"/> Bender ^{**} (Elbow/Shoulder) | <input type="checkbox"/> McCarroll ⁺ (Sports Med/Triage) | <input type="checkbox"/> Smerek ^{**~} (Foot/Ankle) |
| <input type="checkbox"/> Boaz ⁺ (Concussion) | <input type="checkbox"/> Miller ⁺ (Podiatry) | <input type="checkbox"/> Snead ^{**~} (Upper Extremity) |
| <input type="checkbox"/> Conduct ^{**~} (Total Hip/Knee) | <input type="checkbox"/> Misamore ⁺ (Shoulders) | <input type="checkbox"/> Dellacqua (Hand/Elbow) |
| <input type="checkbox"/> Harman ^{**} (Pain Management) | <input type="checkbox"/> Origer ^{**} (Chiropractic) | <input type="checkbox"/> Gettelfinger (Pain Management) |
| <input type="checkbox"/> Horner ⁺ (Concussions) | <input type="checkbox"/> Peters ⁺ (Spine) | <input type="checkbox"/> Linger (Knee/Shoulder) |
| <input type="checkbox"/> Huffman ⁺ (Podiatry) | <input type="checkbox"/> Porter ^{**} (Foot/Ankle) | <input type="checkbox"/> Meyers (Upper Extremity) |
| <input type="checkbox"/> Hur ⁺ (Total Hip/Knee) | <input type="checkbox"/> A. Rettig ⁺ (Upper Ext/Knee) | <input type="checkbox"/> Pannunzio (Hand/Elbow) |
| <input type="checkbox"/> Klootwyk ^{**} (Knee) | <input type="checkbox"/> L. Rettig ^{**} (Hand/Elbow) | <input type="checkbox"/> Weidenbener (Sports Med) |
| <input type="checkbox"/> Jagers ⁺ (Knee) | <input type="checkbox"/> M. Ritter ^{**~} (Knee/Shoulder) | <input type="checkbox"/> URGENT |
| <input type="checkbox"/> Maiers ⁺ (Hip/Knee) | <input type="checkbox"/> S. Ritter ^{**} (Spine) | <input type="checkbox"/> FIRST AVAILABLE |

Problem that we are seeing the patient for: _____

Is the problem related to an auto accident: _____

Is the problem work related: _____

Has the patient had any xrays or MRI? _____

****Please have patients bring films/CD with them to their appointment.****

Referring Physician: _____ Phone Number: _____

Contact Person: _____ Extension: _____

*****Please fax all records with copy of insurance card to 317-819-1209.*****