Cape Fear Orthopedics
& Sports Medicine

APPOINTMENT REQUEST FORM

Phone: (910) 484-2171 Fax: (910) 484-4568

Patient Name:_____ ❑ Male ❑ Female

SSN: _____ Date of Birth: _____ Daytime Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Type: _____ Referring Physician: _____ Phone:_____

PLEASE ATTACH COPIES OF THE FOLLOWING INFORMATION:

1. COPIES OF INSURANCE CARD(S) 2. RELATED OFFICE NOTES & TEST RESULTS

THERE MAY BE A DELAY IN SCHEDULING APPOINTMENTS IF ALL INFORMATION IS NOT RECEIVED

Reason for Referral/Consult: (If the injury is a fracture, please tell us the injury date) DOI: _____

_____ Ankle	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Elbow	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Foot/Toe(s)	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Hand/Finger(s)	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Hip	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Knee	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Shoulder	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Spine	❑ Cervical	❑ Thoracic	❑ Lumbar	Diagnosis: _____
_____ Wrist	❑ Right	❑ Left	❑ Bilateral	Diagnosis: _____
_____ Other: _____				Diagnosis: _____

Patient has had the following tests (please check all that apply):

❑ X-rays ❑ MRI ❑ NCV/EMG ❑ DXA Scan ❑ Other _____ ❑ None

Has the patient ever been treated by an orthopedic surgeon for this injury/problem?

❑ No ❑ Yes - When/by whom? _____ ❑ Unknown

Has the patient ever had surgery for this injury/problem? ❑ **Yes** ❑ **No** ❑ **Unknown**

If yes,what type of surgery and who performed it? _____

Is this a worker's compensation injury/problem? ❑ **Yes** ❑ **No** ❑ **Unknown**

Is a specific provider requested?

❑ Any provider	❑ Dr. Kouba	❑ Dr. Broussard	❑ Dr. Levine	❑ Dr. Eck	❑ Dr. Staneata
(includes physician assistant)	❑ Dr. Greene	❑ Dr. Newman	❑ Dr. Flanagan	❑ Dr. Lowe	❑ Dr. Kozanek

Is a specific location requested?

❑ Ferncreek Drive ❑ Ramsey Street ❑ Raeford Road (Hoke side) ❑ No preference

FOR OFFICE USE ONLY

Appt Date: _____ Time: _____ ❑ Ferncreek Drive ❑ Ramsey Street ❑ Raeford Road

Appointment scheduled with: Dr. _____ PA _____ Scheduler Initials _____

Patient Notified on _____ BY ❑ phone ❑ mail ❑ voice mail ❑ other

Referring Office Notified on _____ BY ❑ fax ❑ phone

Comment _____