Specialty Service Referral

Southern Illinois Hand Center

Sarah Bush Lincoln

SBL Southern Illinois Hand Center
SBL Medical Park Plaza
901 Medical Park Dr., Suite 100 • Effingham, IL 62401
217-347-3003 • Fax 217-347-3005

REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral _____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related ❑ Yes ❑ No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

INFORMATION NEEDED

Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
- ❑ Medication and Allergy Lists

Date of Injury _____

Please check the following that apply:

- ❑ Fracture
- ❑ Laceration
- ❑ Patient splinted
- ❑ Sutures
- ❑ Infection
- ❑ Receiving pain medications
- ❑ Receiving antibiotics

Surgery Pertaining to this Problem ❑ Yes ❑ No

Type of Surgery _____

Date _____

Where _____

Provider _____

Preferred Provider _____

Appointment Urgency ❑ First available ❑ Urgent

Imaging Information

Please check the following that apply:

- ❑ EMG Date _____ Where _____
- ❑ MRI/CT Date _____ Where _____
- ❑ Xray Date _____ Where _____

REFERRING RESPONSE

❑ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____