Specialty Service Referral

Orthopedics, Podiatry, Neurosurgery and Spine Services

Sarah Bush Lincoln

SBL Orthopedics and Sports Medicine
Prairie Pavilion 2
1004 Health Center Dr., Suite 100 • Mattoon, IL 61938
217-238-3435 • fax 217-238-3492

SBL Bonutti Clinic
1303 West Evergreen Ave., Suite 200 • Effingham, IL 62401
217-342-3400 • fax 217-342-6417

SBL Neurosurgery
SBL Deerpath Medical • 100 Deerpath Rd. • Charleston, IL 61920
217-345-4982 • fax 217-348-6345

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 _____

Pre-certification must be done by the referring provider's office prior to referral being review.

INFORMATION NEEDED
Please include all the information below.

- ❑ Provider Notes
- ❑ Procedure Reports
- ❑ Appropriate Laboratory Reports
- ❑ Appropriate Imaging Reports
  — MRI required within past 6 months
- ❑ Medication and Allergy Lists
- ❑ Lumbar referrals require a BMI at or below 40

Please indicate specialty needed for referral.

_____

Preferred Provider

_____

Appointment Urgency

- ❑ First available
- ❑ Urgent

REFERRING RESPONSE

❑ Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

❑ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____