

Specialty Service Referral

Southern Illinois Hand Center

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.

- ☐ Physician Notes
- ☐ Procedure Reports
- ☐ Appropriate Laboratory Reports
- ☐ Appropriate Imaging Reports
- ☐ Medication and Allergy Lists

Date of Injury _____

Please check the following that apply:

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

Imaging Information

Please check the following that apply:

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

Surgery Pertaining to this Problem ☐ Yes ☐ No

Type of Surgery _____

Date _____

Where _____

Provider _____

Preferred Physician _____

Appointment Urgency ☐ First available ☐ Urgent

REFERRING RESPONSE

- ☐ Patient Scheduled

Physician _____ Date _____ Time _____

Comment _____

- ☐ Patient NOT Scheduled

Additional Information Required _____

Other Reason _____