ORTHOPEDIC
FOOT & ANKLE CENTER

An OrthoAlliance Partner Practice

Patient Referral Appointment Request

Upon completion, please send form via Fax: (614) 895-8810 or email to ofaappts@orthofootankle.com

For your records, confirmation will be faxed upon completion of requested referral.

Referring Office Information

Your Name/Office: _____ Phone: (____)_____

Referring Physician: _____ Fax Number: (____)_____

Address: _____

Reason for Referral: _____

Orthopedic Foot & Ankle Physician Preference: _____

Patient Information

Patient Name: _____ Gender: ___Male ___Female

Address:_____
City:_____ State: _____ Zip: _____
Home Phone: (____) _____ Mobile Phone: (____)_____

Date of Birth: ___/____/____

Interpreter Needed: ____ Yes ____ No Language: _____

Patient Insurance Carrier: _____

Please attach patient demographics, insurance card, and any pertinent medical records. We appreciate your completion of this form in its entirety to allow us to better serve your patient.

Testing/Imaging Performed (please check box)

☐ Weigh Bearing X-Rays ☐ MRI ☐ CT ☐ Bone Scan

**The patient will need to bring any imaging, reports, and other results pertaining to this issue.

If you have difficulty during the appointment scheduling process,
please contact our office at **(614) 895-8747, option #3.**
THANK YOU FOR YOUR REFERRAL!

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