Collom & Carney Clinic ASSOCIATION

**** *Consult / Referral Forms are now available on-line at www.collom-carney.com* ****

5002 Cowhorn Creek Drive
Texarkana, Tx. 75503
Phone: (903) 614-3008
Fax: (903) 614-3511 –

ORTHOPEDICS

☐ **CONSULT** (Request for advice / opinion) **or** ☐ **REFERRAL** (Request for management of care)
(Please only select one request)

REQUESTING PROVIDER INFORMATION

Requesting Provider Name	Requesting Provider Address (street, city, state, zip)

Requesting Provider Telephone	Requesting Provider Fax Number	NPI #
( ) -	( ) -	

APPOINTMENT REQUEST

DIAGNOSIS: _____

ORTHO Fax: (903)614-3511 ☐ **First Available**
☐ **Douglas Thompson, MD**
☐ **Thomas Young, MD**

Patient must bring MRI/CT film or disc to appointment and radiology.● Please fax all of the following information: Legible copies of insurance cards (both sides).● PCP referral if required.● Current MRI/x-ray report. ● Most recent pertinent progress note.

If all of the above information is not sent , we will not be able to schedule an appointment until it is received.

PATIENT and INSURANCE INFORMATION

Patient Name (First, Middle Initial, Last)	Gender
	☐ Male ☐ Female

Address	City, State, Zip

Date of Birth (mm/dd/yyyy)	Social Security #

Home Telephone	Mobile Telephone	Work Telephone
( ) -	( ) -	( ) - xtn

Does patient need an interpreter?	If yes, what language?
☐ Y ☐ N	

Does the patient have medical insurance?	Name of Insurance Company and Plan Number and Group Number
☐ Y ☐ N	

Please provide consulting physician with all applicable CLINIC NOTES, HISTORY & PHYSICAL, PREVIOUS PROCEDURES, LABORATORY RESULTS, PATHOLOGY REPORTS, RADIOLOGY REPORTS, AND OPERATIVE REPORTS pertinent to the patients visit. Please fax all documentation to (903) 614-3511.
Thank you in advance for the request and your cooperation.

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