



UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE

UNIVERSITY SPECIALTY CLINICS®

ORTHOPAEDIC CONSULTATION REQUEST

DATE: _____

REFERRING DOCTOR: _____

PRACTICE/GROUP: _____

PERSON TO CONTACT: _____ PHONE # (____) _____

REFERRAL TO DOCTOR: _____

REASON FOR CONSULTATION: _____

HAS THE PATIENT SEEN ANOTHER ORTHOPAEDIST FOR THIS PREVIOUSLY? _____

IF SO WHO: _____

PATIENT INFO:

PATIENT NAME: _____ PHONE (____) _____

DATE OF BIRTH: ____/____/____ SS# ____-____-____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PRIMARY INSURANCE:

TYPE OF INSURANCE: _____

SUBSCRIBER NAME: _____ DOB ____/____/____

RELATIONSHIP TO PATIENT: _____

ADDRESS TO MAIL CLAIMS TO: _____

POLICY ID # _____ GROUP # _____

SECONDARY INSURANCE:

TYPE OF INSURANCE: _____

SUBSCRIBER NAME: _____ DOB ____/____/____

RELATIONSHIP TO PATIENT: _____

ADDRESS TO MAIL CLAIMS TO: _____

POLICY ID # _____ GROUP # _____

**PLEASE FAX ALL REFERRALS AND CURRENT MEDICAL RECORDS/NOTES
THAT APPLY TO 803-434-3878 OR BACK UP FAX 803-434-7306. ANY
QUESTIONS PLEASE CALL 803-434-7121. THANK YOU!**

DEPARTMENT OF ORTHOPAEDIC SURGERY
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803-434-6812, FAX 803-434-7306