ORTHOMIDWEST, PLLC. D/B/A

OrthoIllinois® ROCKFORD

# Musculoskeletal & Diagnostic Consultation / Service Request

**Please complete. WE CANNOT PROCESS REQUEST UNTIL REQUIRED INFORMATION IS PROVIDED**

☐ **First available appropriate specialist , or requested specialist indicated below :**

## ORTHOPEDIC

**Joint Replacement - Hip & Knee**
- ☐ Mark Barba, MD
- ☐ John Bottros, MD
- ☐ Mark Oyer, MD
- ☐ Jeremy Pflederer, MD

**Joint Replacement - Shoulder**
- ☐ Brian Bear, MD, FAAOS
- ☐ Scott Trenhaile, MD
- ☐ Jon Whitehurst, MD

**Sports Medicine - Arthroscopic Shoulder & Knee**
- ☐ Scott Trenhaile, MD **(+ Elbow)**
- ☐ Jon Whitehurst, MD
- ☐ Geoffrey Van Thiel, MD **(+ Hip)**

**Pediatric**
- ☐ Scott Ferry, MD

**Spine** (Non-op spine see Physical Medicine & Rehabilitation)
- ☐ Michael Roh, MD
- ☐ Christopher Sliva, MD

## ORTHOPEDIC

**Hand / Elbow**
- ☐ Brian Bear, MD
- ☐ Kenneth Korcek, MD
- ☐ Edric Schwartz, MD
- ☐ Brian Foster, MD

**Trauma / Fracture Care**
- ☐ Marc A. Zussman, MD
- ☐ Jeffrey Earhart, MD

## PODIATRY

*Foot & Ankle Surgery - Routine care services NOT offered (corns, calluses, etc.)*
- ☐ Giovanni Incandela, DPM
- ☐ Douglas Pacaccio, DPM, FACFAS
- ☐ David Thom, DPM

## PHYSICAL MED. & REHAB. / INTERVENTIONAL SPINE

*Interventional pain mgmt., needle EMGs, spasticity, non-op spine care*
- ☐ Ryan Enke, MD
- ☐ Samir Baig, MD, MPH

## RHEUMATOLOGY

*Physicians require up to 1 week to review records before patient will be contacted. Please include all notes and tests when faxing consultation request, along with insurance card to expedite.*
- ☐ Mohit Gupta, MD
- ☐ Andrew Jasek, MD
- ☐ Roel Sanchez, MD
- ☐ Saad Tariq, MD

## THERAPY / REHABILITATION
- ☐ Physical Therapy
- ☐ Neurologic Physical Therapy
- ☐ Hand / Occupational Therapy

## JOYNT PROGRAM

☐ Weight loss program for patients with BMI of 40 or higher needing knee/hip replacement.

## DIAGNOSTIC
- ☐ DEXA scan / read
- ☐ EMG
- ☐ MRI *HMO Authorization or pre-cert*

*#* _____
*(Required)*

## FAX FORM TO: 815.381.7498

**APPOINTMENT PRIORITY:** ☐**Priority** (Next available) ☐**Routine** ☐**Work Comp** ☐**Motor vehicle injury**

Purpose of Request: ☐**Render opinion** ☐**Transfer of care**

**Referring physician:** _____

Contact name: _____ Phone #: _____ Fax #: _____

**Patient name:** _____ **DOB:** _____ Home phone#: _____

Work#: _____ Best time to call: _____

Address: _____

**Insurance:** _____

**Diagnosis** (Be as specific as possible):

_____

_____

_____

**Date of injury:** _____

**Diagnostic Tests completed at:** _____

☐MRI ☐X-rays ☐EMG ☐Bone density ☐Lab tests ☐Last medical note