

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

ORTHOPEDIC

Joint Replacement - Hip & Knee

- ☐ John Daniels, MD
☐ Frank Bohnenkamp, MD
☐ Michael Harvey, MD
☐ Scott Mox, MD
☐ Shawn Palmer, MD

Sports Medicine

- ☐ Rolando Izquierdo, MD
☐ Cort Lawton, MD
☐ Jon Whitehurst, MD
☐ Geoffrey Van Thiel, MD
☐ Jeffrey Kazaglis, MD

Hip Arthroscopy

- ☐ Geoffrey Van Thiel, MD

Hand / Wrist / Elbow

- ☐ Anthony Logli, MD

Orthopedic Spine

- ☐ Tom Stanley, MD
☐ Zachary Goldstein, MD

Pediatric Orthopedics

- ☐ Scott Ferry, MD

Orthopedic Trauma

- ☐ Kevin Carlile, MD

PODIATRY

- ☐ Matthew Sorensen, DPM, FACFAS

PM&R / Interventional Spine

- ☐ Christopher Faubel, MD
☐ Neal Shah, MD

Urgent Injury Care

- ☐ Pradeep Raju, MD
☐ Anthony Rizzo, DO

RHEUMATOLOGY

- ☐ Matas Orentas, DO
☐ Jacqueline Siddiqui, MD

CHIROPRACTIC

- ☐ Scott Spengel, DC

THERAPY / REHABILITATION

- ☐ Physical Therapy
☐ Hand / Occupational Therapy

JOYNT PROGRAM

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

DIAGNOSTIC

- ☐ EMG
☐ MRI *HMO Authorization or pre-cert*

(Required)

FAX FORM TO: 815.381.7498

And instruct patient that OrthoIllinois will contact them to set up appointment.

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 please: _____

Date of injury: _____

Diagnostic Tests completed at: _____

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