Workers' Compensation
Referral Authorization Form

Medicals and Diagnostic reports required prior to scheduling

Email: workers.compensation@orthocarolina.com

Patient Name:	**Date of Birth:**
Preferred Language:	☐ **Male** ☐ **Female**
Patient Mailing Address: Street #, City, State	**Phone #**
Patient Email Address:	**Date of Injury:**
Social Security #:	**Injured Body Part :** ☐ **Right** ☐ **Left** ☐ **Bilateral**
Employer:	**Occupation: Required**
Employer Address:	**Phone#:**
Has this patient received treatment? ***If yes, indicate where (records must be provided)***	**Has surgery occurred for this injury?** ☐ Yes ☐ No
Please advise if patient has had any of the following: Check all that apply- ***If yes, reports are required.*** ☐ **X-rays** ☐ **CT** ☐ **MRI**	
Case Manager Name: ☐ **Telephonic** ☐ **Field**	**Phone #:**
Email Address:	**Fax #:**
WC Insurance Carrier:	**WC Claim #:**
Billing Address:	**Jurisdiction:**
Bill Review Company:	**Telephone/Email Address:**
Adjuster Name:	**Email Address:**
Phone #:	**Fax #:**
Practitioner and/or Location:	

By signing, you are providing approval for OrthoCarolina to:

Consultation **Treatment** **Labs** **X-ray** **EMG/NCS** *(location exceptions Hickory, Laurinburg, Winston)* **CT scans-***(Hand Center / Foot and Ankle Center) SAME DAY CT SCANS- will be scheduled same day as follow up appointment*	PT | SOLUTIONS PHYSICAL THERAPY Preferred therapy provider of OrthoCarolina All Custom Splint/Braces- will be completed by PT Solutions as part of patient Post Operative Care	MedQuest IMAGING NOVANT HEALTH Preferred MRI provider for OrthoCarolina MRI imaging

POST SURGICAL DME Yes ☐ No ☐ (if no please indicate preferred vendor):

Please check who is signing below: **Adjuster** ☐ **Nurse Case Manager** ☐ **Employer** ☐

SIGN HERE	**Date:**

Please sign and Print Name

OrthoCarolina - Workers' Compensation Department
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