



Musculoskeletal, Neurosurgery, & 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
- Victor Antonacci, MD
- John Bottros, 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)

- Brian Braaksma, MD

Hand / Elbow

- Brian Bear, MD
- Kenneth Korcek, MD
- Edric Schwartz, MD
- Brian Foster, MD

Trauma / Fracture Care

- Marc A. Zussman, MD
- Jeffrey Earhart, MD

NEUROSURGERY

- Todd Alexander, MD, SC

PODIATRY

Foot & Ankle Surgery - Routine care services NOT offered (corns, calluses, etc.)

- William Bush, DPM
- Kelly John, DPM, MHA

PHYSICAL MED. & REHAB. / INTERVENTIONAL SPINE

Interventional pain mgmt., needle EMGs, spasticity, non-op spine care

- Ryan Enke, MD
- Zeeshan Ahmad, MD

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.

- David Dansdill, MD
- Andrew Jasek, MD
- Saad Tariq, MD

OCCUPATIONAL MEDICINE

- Robin Borchardt, 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