ORTHOMIDWEST, PLLC. D/B/A

OrthoIllinois® ROCKFORD

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
- ❑ 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)
- ❑ Kamil Okroj, MD
- ❑ 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.)
- ❑ William Bush, DPM
- ❑ 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.
- ❑ Andrew Jasek, MD
- ❑ Zhe Liang, 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