CARIBE MEDICAL CENTER

ORTHOPEDIC, SPINE & PAIN MANAGMENT

PATIENT REFERRAL FORM

PHONE: 407.792.3301 **FAX:** 407.813.2448

SCHEDULING@CARIBEMEDICALCENTERS.COM | CARIBEMEDICALCENTERS.COM

PATIENT NAME: _____ PHONE NUMBER: _____

DATE OF BIRTH: _____ DATE OF ACCIDENT: _____

PATIENT ADDRESS: _____

REFERRING PHYSICIAN: _____

PHYSICIAN PHONE NUMBER: _____ PHYSICIAN FAX NUMBER: _____

ATTORNEY: _____

ATTORNEY PHONE NUMBER: _____ ATTORNEY FAX NUMBER: _____

DOES THE PATIENT HAVE MRI'S? ☐ **NO** ☐ **YES** (If yes, please send the MRI report with the referral.)

PIP INSURANCE CARRIER: _____

INSURANCE PHONE NUMBER: _____ INSURANCE FAX NUMBER: _____

POLICY NUMBER: _____ CLAIM NUMBER: _____

PIP ADJUSTER: _____

ADJUSTER PHONE NUMBER: _____ ADJUSTER FAX NUMBER: _____

BILLING ADDRESS: _____

Reason for Visit:

☐ Interventional Pain Management ☐ Spine ☐ Orthopedic ☐ Final With Impairment Rating

Complaints: ☐ Neck ☐ Back ☐ Shoulder ☐ Knee ☐ Other: _____

REV 11/2024

Please choose a location:

☐ **Orlando |** 6342 W. Colonial Drive, Suite C, Orlando, FL 32818