CAPITAL ORTHO

104 Burney Drive
Flowood, MS 39232
Walk-Ins Welcome

601.987.8200
Fax: 601.586.0596
www.capitalortho.com

745 Clinton Parkway
Clinton, MS 39056
Walk Ins Welcome

Copiah County Medical Center
27190 MS-28
Hazlehurst, MS 39083

Kings Daughters Medical Center
601 Brookman Dr.
Brookhaven, MS 39601

Premiere Medical Group
332 Hwy 12 W
Kosciusko, MS 39090

106 Highland Way, Suite 102
Madison, MS 39110

When using our fax referral service please complete the form entirely and fax it to the number above with the following information. Copies of any radiology reports, medical records pertaining to the referral request and a complete list of medications the patient is taking. Please get an email address and we MUST have the front and back copy of the insurance card. Once the patient is scheduled they will receive an email welcome to our portal and will be able to register and fill out their paperwork online. **Urgent Appointments:** Please call or utilize the walk-in option at our Flowood or Clinton locations.

Date:_____ Referring Clinic Name:_____

Select Physician of Choice: ☐ First Available (any doctor)

☐ Michael G. Dulske, M.D. ☐ G. Andy Brien, M.D. ☐ Matthew C. Futvoye, M.D. ☐ Adam Smitherman, M.D.
☐ E. Jeff Kennedy, M.D. ☐ Chris Kneip, M.D. ☐ Bradley Kellum, M.D. ☐ Daniel Ross, M.D.
☐ William O. McCraney, M.D. ☐ Chad Hosemann, M.D. ☐ Tal Hendrix, M.D. ☐ Turner Brown, M.D.

☐ **Work Comp** ☐ **Automobile** ☐ **Accident** ☐ **Other**_____

Referring Physician Information

First Name	**Middle Name**	**Last Name**	**Practice Phone**

Staff Contact	**Address**	**NPI #**	**Practice Fax**

Primary Complaint

Briefly describe primary complaint

Studies and location of X-Rays, MRI, CT

Patient Information

First Name	Middle Name	Last Name	Date of Birth

Address	City	State	Zip

Cell Phone	Work Phone	Home Phone	Social Security #

Primary Insurance Company	Insurance ID #	Group #	**AUTHORIZATION** # if required for referral

Policy Holders Name	Date of Birth of Policy Holder	Patient's Email Address

Insurance Address	Insurance Phone #

Workers Compensation Cases: Please complete this section

Date of Injury	Has patient had Surgery: Y N Date	Claim Number

Employer	Employer Address

Employer Contact Person	Employer Phone	Employer Fax

WC Carrier's Name	Adjuster's Name	Adjuster's Number & Ext.	Adjuster's Fax

WC Carrier's Address	Adjusters's Email Address

Nurse Case Manager	NCM Email Address	NCM Phone & Ext.	NCM Fax