



104 Burney Drive
Flowood, MS 39232
Walk-Ins Welcome

745 Clinton Parkway
Clinton, MS 39056
Walk-Ins Welcome

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

Phone Number for All Locations
601.987.8200
www.capitalortho.com

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

Premiere Medical Group
332 Hwy 12 W
Kosciusko, MS 39090

106 Highland Way, Suite 102
Madison, MS 39110

Fax completed forms to 601-586-0596
Work Comp referrals, fax to: 601-586-0795 or email workcomp@capitalortho.com

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. Daniel Ross, M.D.
 E. Jeff Kennedy, M.D. Chris Kneip, M.D. Bradley Kellum, M.D. Turner Brown, M.D.
 William O. McCraney, M.D. Chad Hosemann, M.D. Tal Hendrix, 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