PHYSICIANS FAX REFERRAL FORM

The Orthopaedic Group P.C.

Please fax to (251) 338-8582 or email to: appointments@TheOrthoGroup.com

GENERAL PRACTICE

- ☐ **MICHAEL A. ESLAVA, M.D.** *BALDWIN COUNTY*
- ☐ **L. DEAN MASON, II, M.D.** *BALDWIN COUNTY*
- ☐ **ROBERT B. MCGINLEY, M.D.** *MOBILE COUNTY*
- ☐ **GUY L. RUTLEDGE, III, M.D.** *MOBILE COUNTY*
- ☐ **NO PREFERENCE**

JOINT REPLACEMENT CENTER

- ☐ **ROBERT C. BAIRD, III, M.D.** *MOBILE COUNTY*
- ☐ **MICHAEL J. BLACKMER, D.O.** *BALDWIN COUNTY*
- ☐ **CHARLES H. WILSON, IV, M.D.** *MOBILE AND MONROE COUNTY*
- ☐ **NO PREFERENCE**

FOOT & ANKLE CENTER

- ☐ **TIMOTHY L. FRERICHS, M.D.** *BALDWIN COUNTY*
- ☐ **DEREK M. KLAVAS , M.D.** *MOBILE COUNTY*
- ☐ **R. MATTHEW MCKEAN, M.D.** *MOBILE COUNTY*
- ☐ **NO PREFERENCE**

HAND & ELBOW CENTER

- ☐ **THOMAS M. BARBOUR, III, M.D.** *MOBILE AND BALDWIN COUNTY*
- ☐ **SCOTT R. GLENZER, M.D.** *BALDWIN COUNTY*
- ☐ **J. NICHOLAS RACHEL, M.D.** *MOBILE COUNTY*
- ☐ **COLIN W. SWIGLER, M.D.** *MOBILE COUNTY*
- ☐ **NO PREFERENCE**

SPINE CENTER

- ☐ **ANDREW T. HENDERSON, M.D.** *MOBILE & BALDWIN COUNTY*
- ☐ **CLINTON W. HOWARD, IV, M.D.** *MOBILE AND BALDWIN COUNTY*
- ☐ **TODD K. VOLKMAN, M.D.** *MOBILE COUNTY*
- ☐ **JAMES L. WEST, III, M.D.** *MOBILE AND BALDWIN COUNTY*
- ☐ **NO PREFERENCE**

PEDIATRIC CENTER

- ☐ **ADAM J. HANDWERGER, M.D.** *MOBILE AND BALDWIN COUNTY*

SPORTS MEDICINE CENTER

- ☐ **MATTHEW L. BUSBEE, M.D.** *MOBILE COUNTY*
- ☐ **J. MICHAEL COCKRELL, M.D.** *MOBILE COUNTY*
- ☐ **JEFFREY M. CONRAD, M.D.** *MOBILE COUNTY*
- ☐ **TODD D. ENGERSON, M.D.** *MOBILE AND CLARKE COUNTY*
- ☐ **TIMOTHY L. FRERICHS, M.D.** *BALDWIN COUNTY*
- ☐ **JACOB F. KIDDER, M.D.** *MOBILE COUNTY*
- ☐ **TREVOR M. STUBBS, M.D.** *MOBILE AND BALDWIN COUNTY*
- ☐ **CHARLES H. WILSON, IV, M.D.** *MOBILE AND MONROE COUNTY*
- ☐ **NO PREFERENCE**

Location: ☐ Airport Boulevard ☐ Gulf Shores Clinic ☐ Fairhope Office ☐ Foley Office ☐ Monroeville Clinic ☐ Orange Beach Clinic ☐ Saraland Office ☐ Springhill Avenue ☐ Thomasville Clinic ☐ No Preference

Requested Appointment Day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ No Preference

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We will contact your patient and schedule their appointment.

Referring Physician: _____ Contact Person: _____

Telephone Number: _____ Fax Number: _____

Patient's Name: _____ Date of Birth: _____

Phone Number: Cell: _____ Home: _____ Diagnosis: _____

Insurance: _____ Policy Holder: _____ Policy #: _____ Group #: _____

*If patient demographic sheet is available, please fax along with referral form.

Has the Patient had prior treatment or surgery for this issue? ☐ Yes ☐ No

* If previous studies exist, please bring films & copy of report(s) to aid in patient evaluation.

APPOINTMENT: Date: _____ Time: _____ Locations: _____

For same day appointments, call our Dedicated Physician Referral Line (251) 450-1260