APPOMMENT REQUEST FORM

PLEASE COMPLETE THIS FORM IN FULL. PLEASE FAX TO 256.704.0878 OR EMAIL TO referrals@sportsmedlink.com. WE WILL CONTACT YOUR PATIENT, SCHEDULE THE APPOINTMENT AND RETURN THE FORM WITH APPOINTMENT DATE AND TIME.

REFERRING PHYSICIAN ____________________________________________ NPI ____________________________
PHONE _________________________ FAX ____________________________
CONTACT _________________________
ADDRESS ______________________________________________________

PREFERRED PHYSICIAN OR FIRST AVAILABLE (CHOOSE ONE)
☐ FIRST AVAILABLE ☐ WORKERS’ COMP (please check box if this is a work comp patient.)

ORTHOPEDIC SURGERY
☐ H. COBB ALEXANDER, M.D.
☐ MATTHEW D. CLAYTON, M.D.
☐ BRETT FRANKLIN, M.D.
☐ BEATRIZ E. GARCIA-CARDONA, M.D.
☐ ERIC W. JANSSEN, M.D.
☐ TROY A. LAYTON, M.D.
☐ JONATHAN LUDWIG, M.D.
☐ MATTHEW MCDONALD, MD
☐ JACK W. MOORE, M.D.
☐ MATTHEW T. OWEN, M.D.
☐ WILLIAM SYKES, DO
☐ RANDAIL TINDELL, M.D.
☐ JOHN H. WALKER, M.D.

NEUROSURGERY
☐ SANAT DIXIT, M.D.
☐ JOHN D. JOHNSON, M.D.

PHYSIATRY
☐ KRISTINA JANSSEN DONOVAN, D.O.
☐ RYAN AARON, M.D.

PAIN MEDICINE
☐ VICTOR CHIN, M.D.

PODIATRY
☐ ANGELA L. HAMPTON, D.P.M.
☐ ROBERT OCAMPO, D.P.M.
☐ MILTON W. STERLING II, D.P.M.

SPINE SURGERY
☐ CURT FREUDENGERGER, M.D.
☐ JAVIER A. RETO, M.D.

☐ PHYSICAL THERAPY

TO SCHEDULE WITH PHYSICAL THERAPY, PLEASE CALL 256-319-8500 FAX OR EMAIL FORM TO 256-319-8503 or pt@sportsmedlink.com

PREFERRED LOCATION ☐ HUNTSVILLE ☐ MADISON ☐ DECATUR ☐ ATHENS

PATIENT NAME ____________________________________________
DOB _________________________ PHONE _________________________
ADDRESS ______________________________________________________
REASON FOR REFERRAL ________________________________________

INSURANCE __________________________________________________
POLICY # _________________________
GROUP # _________________________

You may also fax or email us a copy of the patient’s insurance card (front and back).

PLEASE SEND PATIENTS WITH ANY AVAILABLE FILMS AND REPORTS TO THEIR APPOINTMENT.
SCHEDULED DATE & TIME _________________________

We will contact your patient within 24 hours and fax a confirmation of the appointment date and time to the number listed above. Thank you for your referral.
You may also find this form for download at www.sportsmedalabama.com