



Patient Referral Form

Date: _____

Patient Name: _____ Date of Birth: _____

- Demographics included
- Recent imaging sent (within 6 months)

Diagnosis:

- Knee Pain: R L B
- Hip Pain: R L B
- Other: R L B

Referring Physician: _____

Phone #: _____ Fax #: _____



Michael E. Berend, MD



Wesley G. Lackey, MD



Joshua L. Carter, MD



Todd E. Bertrand, MD

Same-week appointments available!
Over 40 years of experience in hip and knee surgery.