TOC The Orthopaedic Center
ORTHOPAEDICS, SPINE & SPORTS MEDICINE
World-Class Expertise. Exceptional Care.

TOC Physician FAX Referral Form

Please Fax to: (256) 705-3199

Schedule Appointment with: (Please check preferred physician or first available)

ORTHOPAEDIC SURGEONS

- ☐ Patrick **Boyett**, DO
- ☐ Steven **Buckley**, MD
- ☐ Michael **Cantrell**, MD
- ☐ Joseph **Clark**, MD
- ☐ Stanton **Davis**, MD
- ☐ John **Greco**, MD
- ☐ David **Griffin**, MD
- ☐ James **Hughey**, III DO
- ☐ Michael **Lawley**, MD
- ☐ William **Lawrence**, DO
- ☐ Mark **Leberte**, MD
- ☐ Su **Madanagopal**, MD
- ☐ Philip **Maddox**, MD
- ☐ Allan **Maples**, MD
- ☐ Howard **Miller**, MD
- ☐ Christopher **Parks**, MD
- ☐ Matthew **Smith**, DO
- ☐ Eric **Stanford**, DO
- ☐ Thomas **Thomasson**, MD

ORTHO NON-SURGICAL

- ☐ Jason **Hatfield**, DO
- ☐ Michael **Miller**, MD

FOOT & ANKLE

- ☐ Matthew **DeOrio**, MD
- ☐ David **Kyle**, DPM
- ☐ Jeff **McKee**, DPM
- ☐ Bradley **Sabatini**, MD

SPINE SURGEONS

- ☐ Blake **Boyett**, DO
- ☐ Larry **Parker**, MD
- ☐ John **Rodriguez-Feo**, MD
- ☐ Calame **Sammons**, MD
- ☐ Brian **Scholl**, MD
- ☐ Morris **Seymour**, MD
- ☐ Murray **Spruiell**, MD

SPINE NON-SURGICAL

- ☐ Brian **Carter**, MD
- ☐ Michael **Cosgrove**, MD
- ☐ Jason **Hatfield**, DO
- ☐ Craig **Lincoln**, MD
- ☐ Vandana **Maladkar**, MD
- ☐ Sara **Nadella**, MD
- ☐ Shane **Palmer**, PA

PAIN MANAGEMENT

- ☐ Michael **Cosgrove**, MD

Is this a (please check): ☐ New Patient ☐ Existing Patient with a new problem ☐ Existing Patient with an old problem

Location: ☐ **First Available** ☐ **Huntsville Main** ☐ **Ardmore** ☐ **Athens** ☐ **Boaz** ☐ **Decatur** ☐ **Fayetteville** ☐ **Florence** ☐ **Guntersville** ☐ **Huntsville South** ☐ **Madison** ☐ **Rogersville** ☐ **Scottsboro** ☐ **Winfield**

Referring Physician: ____________________

Contact Person: ____________________

Physician Phone #: ____________________

Fax Number: ____________________

Patient Name: ____________________

Date of Birth: ____________________

Address: ____________________

City/State/Zip: ____________________

Email: ____________________

Patient Phone #: ____________________

Gender (please check): ☐ Female ☐ Male

Alternate Phone #: ____________________

Insurance: ____________________

Where is the pain? (Please check all that apply)

☐ Neck	☐ Upper Back	☐ Elbow	☐ Foot
☐ Shoulder	☐ Lower Back	☐ Hand	☐ Ankle
☐ Hip	☐ Arm	☐ Knee	☐ Other: (Please specify)____________

Was patient involved in a motor vehicle accident? ☐ No ☐ Yes If Yes, Date:____________

Previous Studies: ☐ X-Ray ☐ Myelogram ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ EMG/NCS

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

*For the following Appointments with Drs. Maladkar and Nadella only:

EMG/NCS (please specify extremity): ____________________

Evaluation/Treatment: ____________________

DX/Comments

FOR TOC USE ONLY

Appointment Comments: ____________________