GOLDEN STATE
ORTHOPEDICS & SPINE

ORTHOPEDIC REFERRAL FORM

Referring Provider Name: _____

Practice Name: _____

Phone Number: _____ Fax Number: _____

Provider Email (optional): _____

Preferred Contact Method: ☐ Phone ☐ Fax ☐ Email

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Email Address: _____

Insurance Provider: _____

Member ID: _____

REASON FOR REFERRAL (Check all that apply or write in specifics)

- ☐ General Orthopedic Evaluation
- ☐ Joint/Arthritis
- ☐ Back/Spine
- ☐ Foot/Ankle
- ☐ Pre-Operative Evaluation
- ☐ Imaging Review Only
- ☐ Fracture or Injury Care
- ☐ Sports Injury
- ☐ Hand/Wrist
- ☐ Shoulder/Elbow
- ☐ Post-operative Follow-up
- ☐ Interventional Pain Management

Other: _____

PREFERRED SPECIALTY OR PHYSICIAN (if known): _____

RELEVANT CLINICAL INFORMATION (Please attach relevant documents or list below)

- ☐ Clinical notes
- ☐ Lab results
- ☐ Medication list
- ☐ Imaging reports (X-ray, MRI, CT, etc.)
- ☐ Prior treatments

Comments or Special Considerations: _____

_____

ATTACHMENTS

- ☐ Included with this form
- ☐ Sent separately via fax/email
- ☐ Available on EMR

Referring Provider Signature: _____ Date: _____

Submit this form by:

1. Fax
   - East Bay: 925-933-2912
   - South Bay: 408-412-8137
2. Email: info@goldenstateortho.com
3. OR: Hand this form to your patient to bring to their appointment.