For Office Use

Name:
Chart:
Date:
Update:

Baldwin
Bone & Joint PC

Keeping You in the Game!

WORKERS' COMPENSATION REFERRAL FORM

Patient's Telephone # _____ Patient's SS # _____

Patient DOB _____

Employer Name _____

Address _____

Date of Injury _____ Body Part Involved _____

Employer Contact Person _____

Employer Telephone Number _____ Fax # _____

WC Carrier _____

Carrier Billing Address _____

Adjustor _____

Adjustor Telephone Number _____ Fax # _____

E-mail Address _____

Claim Number _____

Case Manager _____ Ph #_____ Fax # _____

E-mail Address _____

Approval for PA or CNP_____ Date _____

WC visit approved? ☐ Yes ☐ No

Approved by _____ Date _____

Appointment Date _____ Appt. Time _____

Which Dr. Is Appt. With? _____

X-Rays/Other Tests Taken? _____

NOTE: If a doctor's office refers a Workers' Comp patient, you still need to check with the patient's employer to be sure we are approved to see the patient.

Please fax completed form to (251) 625-3198.