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Orthopaedic Clinics
 2211 Lomas Blvd NE, 87106
 1101 – 5 Medical Arts Blvd., 87102
 1213 University Blvd., 87102

Appointments will only be scheduled once all required information is received.

Adult Orthopaedic Referral Sheet for Patients

PATIENT INFORMATION			
Name		Date of Birth	UNMH MRN
Address		Phone #	Work #
City/State/Zip Code		SSN	
Insurance Please contact your Insurance for prior authorization before your appointment. Patient is untimely responsible for the bill.	<input type="checkbox"/> Self-Pay Please Note: We are not contracted with Pres SCI Pres Senior Pres Employees Beech Street Amerigroup <i>*Contact clinic for full list.</i>	Primary Insurance: Name Address Policy Holder: Name DOB ID# Group#	Secondary Insurance: Name Address Policy Holder: Name DOB ID# Group#

REFERRING PROVIDER/PRIMARY CARE PHYSICIAN INFORMATION	
Name	Office Contact
Address	Phone #
City/State/Zip Code	Fax #
Organization Name	PCP

REASON FOR VISIT			
All referrals MUST include: 1) Completed referral sheet including insurance information 2) Last clinical notes related to diagnosis 3) Diagnostic test results completed within the last 6 months PLEASE SEE BELOW FOR REQUIRED DIAGNOSTIC STUDIES DEPENDENT ON DIAGNOSIS			
Back/Neck Pain: MRI <input type="checkbox"/>	Fractures: Radiographs <input type="checkbox"/>	Podiatry: <input type="checkbox"/>	Previous Orthopaedic Operation Operative Notes <input type="checkbox"/>
Joint Revision: MRI <input type="checkbox"/>	Carpal Tunnel Syndrome: EMG <input type="checkbox"/>	Spine Fracture: CT of Spine without Contrast <input type="checkbox"/>	
Hand and Microsurgery: Radiographs <input type="checkbox"/>	Foot and Ankle: Radiographs <input type="checkbox"/>	Sports Medicine : Radiographs and or MRI <input type="checkbox"/>	

****ORTHOPAEDICS DOES NOT MANAGE CHRONIC PAIN OR PRESCRIBE PAIN MEDICATION TO NON-SURGICAL PATIENTS****

Appointment Information: _____ at _____ with Dr. _____
 Location _____ **PATIENT MUST BRING FILMS/DISCS TO APPT.**



THE UNIVERSITY OF NEW MEXICO ♦ HEALTH SCIENCES CENTER

UNM HOSPITALS

MRN _____

Patient Name: _____ DOB: _____

Date of Injury _____ On-The-Job Injury Auto Accident Sports Injury

Other _____

Is there (or will there be) an attorney involved with this problem? Yes No

Reason for Visit (Describe problem/injury/symptoms) (Right or Left side?) _____

Previous Treatment for this Problem
(If none, skip to next section)

Physicians/Providers Seen: _____

Arthrogram Date _____ Facility _____

Bone Scan Date _____ Facility _____

Casting/Splinting
Date _____ Facility _____

Chiropractic/Acupuncture
Date _____ Facility _____

EMG/Nerve Study
Date _____ Facility _____

Injection Date _____ Facility _____

MRI Date _____ Facility _____

Physical Therapy
Date _____ Facility _____

Vascular Studies
Date _____ Facility _____

X-Rays Date _____ Facility _____

Other Date _____ Explain _____

Relieving Factors:
Makes the problem/pain better?

Acetaminophen/Tylenol Muscle Relaxants

Anti-Inflammatory/Ibuprofen Prescription Pain Medication

Aspirin Rest

Physical Therapy Sling

Crutches Heat

Elastic Wrap Compression Heat

Ice

Other _____

Aggravating Factors:
Makes the problem/pain worse?

- | | |
|--|---|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Movement of Area |
| <input type="checkbox"/> Deep Breath | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Direct Pressure | <input type="checkbox"/> Weight Bearing |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Grasping |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Other _____ |

Type of Pain

- | | | |
|----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Numbness | <input type="checkbox"/> Pins & Needles |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Severe |

Describe the severity of the pain:

0= None /10=Worst

0 1 2 3 4 5 6 7 8 9 10

Where are your symptoms now?

Mark the location of your pain on the picture below. Place an **X** over the area of your pain.

