

Specialty Service Referral
Orthopedics, Podiatry,
Neurosurgery and
Spine Services

SBL Orthopedics and Sports Medicine
 Prairie Pavilion 2
 1004 Health Center Dr., Suite 100 • Mattoon, IL 61938
 217-238-3435 • fax 217-238-3492



SBL Bonutti Clinic
 1303 West Evergreen Ave., Suite 200 • Effingham, IL 62401
 217-342-3400 • fax 217-342-6417

SBL Neurosurgery
 Deerpath Medical • 100 Deerpath Rd., Charleston, IL 61920
 217-345-4982 • fax 217-348-6345

REFERRING PROVIDER

Name _____ Phone _____ Fax _____

Reason for Referral _____

_____ Date _____

PATIENT INFORMATION

Name _____ Date of Birth _____ Social Security Last 4# _____

Address _____ City _____ State/Zip _____

Phone _____ County _____

Insurance Carrier Primary _____ Secondary _____

If HMO/POS or United Healthcare insurance plan, referral authorization to be obtained by referring office. Authorization # _____

Work Related Yes No If yes, Employer _____ Contact _____

Work Comp Carrier _____ Contact _____

Pre-certification must be done by the referring provider's office prior to referral being review.

INFORMATION NEEDED

Please include all the information below.

Provider Notes

Procedure Reports

Appropriate Laboratory Reports

Appropriate Imaging Reports
 — MRI required within past 6 months

Medication and Allergy Lists

Lumbar referrals require a BMI at or below 40

Please indicate specialty needed for referral.

Preferred Provider

Appointment Urgency

First available

Urgent

REFERRING RESPONSE

Patient Scheduled

Provider _____ Date _____ Time _____

Comment _____

Patient NOT Scheduled

Additional Information Required _____

Other Reason _____