

Specialty Service Referral Southern Illinois Hand Center

SBL Southern Illinois Hand Center
SBL Medical Park Plaza
901 Medical Park Dr., Suite 100 • Effingham, IL 62401
217-347-3003 • Fax 217-347-3005



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 _____

INFORMATION NEEDED

Please include all the information below.

- Provider Notes
- Procedure Reports
- Appropriate Laboratory Reports
- Appropriate Imaging Reports
- Medication and Allergy Lists

Date of Injury _____

Please check the following that apply:

- Fracture
- Laceration
- Patient splinted
- Receiving pain medications

Imaging Information

Please check the following that apply:

- EMG Date _____ Where _____
- MRI Date _____ Where _____
- Xray Date _____ Where _____

REFERRING RESPONSE

- Patient Scheduled
Provider _____ Date _____ Time _____
Comment _____
- Patient NOT Scheduled
Additional Information Required _____
Other Reason _____