

## FAX REFERRAL FORM

Lebanon Office  
1035 South Hartmann Dr.  
Lebanon, TN 37090

**Fax To: 615.443.5488**

**Joint Replacement**

☐ William B. Kurtz II, M.D.

**Physical Medicine  
and Rehabilitation**

☐ Christopher P. Ashley, M.D.

**Sports Medicine**

☐ Martha P. George, M.D.

**Shoulder**

☐ Martha P. George, M.D.

☐ James H. Rubright, M.D.

DATE: \_\_\_\_\_ FROM \_\_\_\_\_ PHONE: \_\_\_\_\_  
REFERRING MD: \_\_\_\_\_ FAX: \_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_ NUMBER OF PAGES: \_\_\_\_\_

**PATIENT INFORMATION**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

INSURANCE: \_\_\_\_\_

REFERRED FOR: ☐ SHOULDER ☐ SPINE ☐ KNEE  
☐ ELBOW ☐ HIP ☐ OTHER \_\_\_\_\_  
☐ HAND / WRIST

DIAGNOSIS: \_\_\_\_\_

**PLEASE FAX PERTINENT MEDICAL RECORDS, TESTS, AND INSURANCE CARDS**

**FOR TOA STAFF USE**

Communication with Patient \_\_\_\_\_

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

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