



The Doctors Hospital of Tattall

## WORKERS' COMPENSATION PATIENT REFERRAL FORM

### EMPLOYEE information:

Employee Name \_\_\_\_\_

*FIRST MIDDLE LAST*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### EMPLOYER Information:

Name of Business \_\_\_\_\_

Name of Contact \_\_\_\_\_ Phone \_\_\_\_\_

### WORK COMP INSURANCE Information:

W/C Insurance Name \_\_\_\_\_

Claims Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Authorized by Adjuster's Name \_\_\_\_\_

Phone w/Ext \_\_\_\_\_

Fax \_\_\_\_\_ Authorized to treat for \_\_\_\_\_

CLAIM # \_\_\_\_\_ Date of Injury: \_\_\_\_\_

### REFERRED BY: *ALL MEDICAL RECORDS MUST BE FAXED W/REFERRAL*

Referring Doctor \_\_\_\_\_ Contact Name \_\_\_\_\_

Phone \_\_\_\_\_

Referring for (circle one) - **2<sup>nd</sup> opinion**    **Eval/treat**    **take over treatment**

**FAX THIS COMPLETED FORM TO 912-644-6190**

**Donna Hatcher – W/C Coordinator Phone 912-644-5384**