Date: _____ First report injury Yes No

# South Texas Bone & Joint

**601 Texan Trail, Suite 300 Corpus Christi, TX 78411**
**Phone: 361-854-0811 Fax: 361-806-5040**

## WORKER'S COMPENSATION REFERRAL FAX FORM

| Physician: (Circle One) | Seger | Masciale | Breckenridge | Borkowski | Grosser | Thomas | Klimisch | Montgomery |
|---|---|---|---|---|---|---|---|---|
| | 806-5031 | 806-5041 | 806-5047 | 806-5036 | 806-5042 | 561-0621 | 561-0631 | 561-0628 |

**EVALUATE & TREAT** **CONSULT ONLY**

**FRACTURE CARE**

PATIENT NAME: _____ DOB:_____ SS#: _____

ADDRESS: _____ CITY/ST/ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____ CELL #: _____

**EMPLOYER:** _____ PHN #: _____FAX #: _____

ADDRESS: _____ CITY/ST/ZIP: _____EMAIL:_____

MEMBER OF A NETWORK: YES NO NETWORK NAME: _____ CONTACT: _____ PHN #: _____

DOI: _____ NATURE OF INJURY: _____ RIGHT/LEFT/BILATERAL

For STBJ office use only:
**DOL accepted** **Description** **Dispute _____**
**Condition code: _____** **of code: _____** **Peer Review _____** **Compensability: _____**

**TX W/C** **Non-Subscriber** **Self Insured** **Federal/Longshore** **Dept. of Labor**

**W/C CARRIER:** _____ PHN#: _____ FAX: _____

ADDRESS: _____ CITY/ST/ZIP: _____

CLAIM #: _____ ADJUSTER: _____ FAX: _____

PHN #: _____ EXT: _____ FAX # FOR REPORTS: _____

PRECERT #: _____ FAX: _____

For STBJ office use only:
Verified by: _____ Date: _____ OACC employee: _____ Date: _____

REFERRED BY: _____ PHN #: _____ TREATING PHYSICIAN: _____

CONTACT PERSON: _____ PHN #: _____ Email: _____

For STBJ office use only:

Appt time: _____ Appt date: _____ Appt made by: _____

Thank you for choosing South Texas Bone & Joint

Updated Jan. 2015