

NAME:  
MEDICAL RECORD #:  
BIRTHDATE:  
PCP:

<b>AREA TO BE EXAMINED / TYPE OF EXAMINATION</b>  <input type="checkbox"/> In Plaster / Fiberglass <input type="checkbox"/> Out of Plaster / Fiberglass	SCHEDULED DATE:	SEND PHYSICIAN'S PERSONAL COPY TO: NAME: _____ M.D. FIRST LAST
	<b>DIAGNOSIS OR CLINICAL SUSPICION (REQUIRED)</b> <b>Rule out diagnosis not acceptable</b>  <input type="checkbox"/> Injury <input type="checkbox"/> Fracture Open <input type="checkbox"/> Fracture Closed <input type="checkbox"/> Dislocation <input type="checkbox"/> Sprain  ICD-9 Codes	ADDRESS  STREET CITY ZIP  <b>PHYSICIAN'S SIGNATURE</b> ATTENDING _____  RESIDENT _____ BEEPER _____

**HISTORY / CLINICAL INFORMATION (REQUIRED)**      PATIENT POTENTIALLY PREGNANT?  NO  YES IF YES, LMP

**Please check all that apply, if not listed please provide a narrative description above.**

<input type="checkbox"/> AC Joint Inflammation <input type="checkbox"/> ACL Insufficiency <input type="checkbox"/> Adhesive Capsulitis/Frozen Shldr. <input type="checkbox"/> Arthrofibrosis Joint <input type="checkbox"/> Avascular Necrosis <input type="checkbox"/> Bunion <input type="checkbox"/> Bursitis elbow <input type="checkbox"/> Bursitis hip <input type="checkbox"/> Bursitis knee <input type="checkbox"/> Bursitis shoulder <input type="checkbox"/> Calcaneal Spur <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Cellulitis & Abscess <input type="checkbox"/> Chondrocalcinosis <input type="checkbox"/> Chondromalacia <input type="checkbox"/> Chondromalacia Patella <input type="checkbox"/> Compartment Syndrome <input type="checkbox"/> CDH <input type="checkbox"/> Cyst-Bone <input type="checkbox"/> Cyst-Meniscus <input type="checkbox"/> Cyst Popliteal/Baker's <input type="checkbox"/> Cyst Synovial <input type="checkbox"/> Diabetic Neuropathy <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Displacement Intervertebral Disc <input type="checkbox"/> Effusion of joint <input type="checkbox"/> Femoral Anteversion/Retroversion <input type="checkbox"/> Flat Foot (Pes Planus) <input type="checkbox"/> Ganglion Wrist <input type="checkbox"/> Gout <input type="checkbox"/> Hallux Rigidus <input type="checkbox"/> Hallux Valgus <input type="checkbox"/> Hammer Toe	<input type="checkbox"/> I.T. Band Syndrome <input type="checkbox"/> Instability Ankle Lateral <input type="checkbox"/> Internal Derangement Knee <input type="checkbox"/> Internal Tibial Torsion <input type="checkbox"/> Leg Length Discrepancy Acquired <input type="checkbox"/> Lesion Bone <input type="checkbox"/> Loose Body Ankle <input type="checkbox"/> Loose Body in Joint (excl. Knee) <input type="checkbox"/> Loose Body Knee <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Mallet Finger <input type="checkbox"/> Malunion Fracture <input type="checkbox"/> Metatarsalgia <input type="checkbox"/> Morton's Neuroma <input type="checkbox"/> Median Neuropathy <input type="checkbox"/> Neck Pain <input type="checkbox"/> Nonunion Fracture <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteochondritis Dissecans Knee <input type="checkbox"/> Osteochondroma <input type="checkbox"/> Osteomyelitis Acute <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Orthopedic Aftercare - plaster cast, pins, wires <input type="checkbox"/> Pain (location) _____ <input type="checkbox"/> Pain in Joint <input type="checkbox"/> Pain in Limb <input type="checkbox"/> Patellar Femoral Pain Syndrome <input type="checkbox"/> Patellar Subluxation <input type="checkbox"/> Pathologic Fracture <input type="checkbox"/> Peripheral Enthesopathy <input type="checkbox"/> Phlebitis Superficial <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Post-op Infection	<input type="checkbox"/> Radiculopathy - lumbar <input type="checkbox"/> Radiculopathy - neck <input type="checkbox"/> Radial Neuropathy <input type="checkbox"/> Reflex Sympathetic Dystrophy - Lower limb <input type="checkbox"/> Reflex Sympathetic Dystrophy - Upper limb <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Rotator Cuff Syndrome <input type="checkbox"/> Sciatic Nerve Injury <input type="checkbox"/> Sciatica <input type="checkbox"/> Scoliosis <input type="checkbox"/> Shin Splints <input type="checkbox"/> Shoulder Subluxation <input type="checkbox"/> S/P Joint Replacement <input type="checkbox"/> Spondylitis <input type="checkbox"/> Spondylolisthesis <input type="checkbox"/> Stress Fracture (pathological) <input type="checkbox"/> Stiffness in joint <input type="checkbox"/> Swelling (location) _____ <input type="checkbox"/> Synovitis, Tenosynovitis <input type="checkbox"/> Tarsal Coalition <input type="checkbox"/> Tarsal Tunnel Syndrome <input type="checkbox"/> Thoracic Spine Pain <input type="checkbox"/> Thrombosis Deep Venous <input type="checkbox"/> Trigger Finger <input type="checkbox"/> Ulnar Neuropathy <input type="checkbox"/> Vertebral Disc disorders
--	--	--