Plymouth
# ORTHOPEDICS & SPORTS MEDICINE CLINIC
*A practice of Speare Memorial Hospital*

Ph: 603-536-1565 Fax: 603-536-1200

Referring Provider: ________________________ date: ________________________
Phone: fax:

## PATIENT INFORMATION:

Patient Name: ______________________________ Date of Birth : _______________
Address: ___________________________________ Home Phone: _______________
___________________________________________ Work phone: ________________
Parent/Guardian: ___________________________ SSN: ________________________
Insurance: _________________________________ Insurance ID# _______________

## REFERRAL INFORMATION

☐ Consultation ☐ Second Opinion ☐ Diagnosis: __________________________
# of Visits Authorized: _________ Start Date: _________ End Date: _____________
Have any diagnostic studies been ordered? Yes or No if so what: _________________
(please have patient hand carry any x-rays, MRI, CT disc. Fax reports to 536-1200)
Urgency ☐ 1-2 days ☐ 1-2 weeks ☐ within a month ☐ next available

## PLEASE CHECK PROVIDER AND/OR AREA OF SPECIALTY

☐ Victor Gennaro, DO Spine and Total Joint Replacement
☐ Total Joint Replacement ☐ Arthroplasty ☐ Endoscopic Carpal Tunnel
☐ Spine ☐ Vertebroplasty ☐ Occupational Injury
☐ Knee Arthroscopy ACL/ Meniscus repair ☐ Arthroscopy
☐ Fracture Care

☐ Michael Giovan, MD Sports Medicine
☐ Shoulder ☐ Rotator cuff repair ☐ Occupational Injury
☐ SLAP tear ☐ Elbow injuries ☐ Open Carpal Tunnel
☐ Sports Injury ☐ Knee Arthroscopy ☐ ACL reconstruction
☐ Fracture Care

## PLEASE CHECK THE APPROPRIATE BOX FOR SCHEDULING

☐ Please contact Patient to schedule appointment
☐ Please contact Patient to schedule appointment AND fax appt date/time to our office.
☐ Please contact our office with appointment information and we will confirm appointment with patient.

☐ PERTINENT MEDICAL RECORDS AND DIAGNOSTIC REPORTS ARE ATTACHED. PATIENT WILL HAND CARRY ANY STUDIES TAKEN.
THANK YOU.

Internal office use only:

Appointment date/time: ________________________ Provider: ____________________