Consultation Request Form

Referring Physician Private Line: 717-747-8320
Appointment Schedule Line for Patient Use: 717-848-4800
Fax: 717-741-9867 or 717-741-0372
www.osshealth.com

Date: ________________ Check one: ☐ Urgent 24-48 Hours ☐ Non-Urgent

Provider (please print) : ________________________ ☐MD ☐DO ☐ CRNP ☐ PA-C ☐Other

Actual Provider Signature Required: ____

Clinical Information:
Symptoms/Reason for Consultation: (please specify when applicable ☐ LEFT, ☐ RIGHT or ☐BILATERAL)

____

ICD 10 Code: (required for EMG/Nerve Conduction Studies and Physical Therapy): _______________________

Special needs: ☐ Interpreter Needed ☐ Hearing Impaired

Please ask the patient to bring a list of their MEDICATIONS, INSURANCE CARD(S), X-RAY FILMS, MRI FILMS, CT FILMS and other pertinent DIAGNOSTIC STUDIES along with them to their appointment.

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Provider Choice: (please check one) ☐ First Available *OR* ☐Specific Provider

Physicians: ☐Orthopaedic ☐Podiatrist (DPM) ☐Pain Mgmt ☐Rheumatology ☐Prim Care/Sports Med

___ Alhadeff, MD
___ Andrews, MD
___ Ashana, MD
___ Bixler, MD
___ Caruthers, DO
___ Christian, MD
___ Curran, DO
___ Elliott, MD (Hand)
___ Etienne, MD
___ Falci, DPM
___ Furman, MD (Pain)
___ Gilhool, DO (Pain)
___ Granger, DPM
___ Grasu, MD
___ Hess, DO (Sports)
___ Hines, DO
___ Jackson, DO
___ Kelley, DO (Sports)
___ King, DO
___ Lin, MD (Pain)
___ Margetas, DO
___ Messner, MD
___ Ortenzio, DPM
___ Pandelidis, MD
___ Patel, MD
___ Pollack, DO
___ Rutter, DO
___ Sicuranza, MD
___ Steinmetz, DO(Pain)
___ Toro, MD (Rheum)
___ Triantafyllou, MD
___ Ulmer, DO
___ Wahlberg (Pain)
___ Welter, DO

Please check a location:
___ 1855 Powder Mill Road, York, PA 17402 717-848-4800
___ 1750 Fifth Avenue, Suite 201, York, PA 17403 717-848-2297
___ 470 Eisenhower Drive, Hanover, PA 17331 717-633-0031
___ 20 Expedition Trail, Suite 110B, Gettysburg, PA 17325 717-339-0700 (Dr. Triantafyllou only)
___ 856 Century Drive, Mechanicsburg, PA 17055 717-730-7099
___ 3230 Eastern Boulevard, York, PA 17402 717-755-0722 (Falci, Hensley, and Ortenzio only)

Physical Therapy: ____
(please list – how many times per week and total number of weeks)

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Patient Name: (print please) ____
(first) (mi) (last)

Name of parent/guardian if patient is a minor: ____

Date-of-Birth: ________ /________ /_________ Phone Number: ___________________________________
Mo Day Year

Insurance: Primary - ____________________________ ID# _________________________________

Secondary - ___________________________ ID# _________________________________

Please fax the insurance REFERRAL if required, AND also a COPY OF THE PATIENT'S INSURANCE CARD.