**Refer a Patient Form**

Thank you for entrusting Tri-County Orthopedics to care for your patients.

To refer your patient for an appointment, please complete this form and **fax** to **303 933 8882.**

Once we receive your request, we will contact your patient directly, usually within 24 hours, to schedule their appointment.

If you have any questions, please contact our office by phone at **(303) 949-1177**.

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**Referring Office Contact Information**

Referring Physician 

Phone Number



Fax Number

If you would like a confirmation of your patient's appointment, please provide your fax number.

**Patient Information**

Patient Name

Age

Date of Birth

Patient Phone Number       Patient Alternative Phone Number (optional) 

Patient Insurance  Company

Patient Insurance Member ID      

Responsible/Insured Party

Symptoms & Diagnostic Codes



Requested time to be seen:

 1-2 days (Urgent)       3-5 days (Soon)       1-2 weeks

If requested to be seen for an urgency, please call our office at **(303) 949 1177**.

Thank you,

Christina Scribner, MS RD CSSD CEDRD  
Encompass Nutrition LLC 8119 Shaffer Parkway, Ste 104, Littleton, CO 80127Bottom of Form