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Orthopedics

NOW ACCEPTING ALL APPROPRIATE MUSCULO-SKELETAL CONDITIONS

EXCEPT:

Spine care, pain management or non-surgical permanent disabilities, or Total Joint Replacement Candidates

Specialist:

Please Select

Ferraro M.D. (hands & wrists only)

Mikulecky M.D. (General Orthopedics)

Referring Physician:

Please Select

**PCP work up
Prior to Referral**

For CTS: NCV/EMGs required
 For Bony Abnormalities/Trauma: X-Rays required
 For soft-tissue or joint injuries/conditions: CT and/or MRI required
 Consider Labs, Bone Scans, etc. when appropriate or helpful in confirming Dx.

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical

Record #:
 Phone: 530-

Critical Condition(s)	Tests Required Prior To Consult: Date they were completed?
Fractures; Bony Abnormalities	Date of X-Ray: Facility:
Carpal Tunnel Syndrome	Date of NCV/EMG: Facility:
For soft tissue joint injuries	Date of CT Scan: Facility: Date of MRI: Facility: Other Diagnostic Tests (labs, scans, etc.)

STAT: NEEDS TO BE DOCTOR TO DOCTOR ONLY

STATS are acute & unmanageable fractures/injuries

Reason for Referral

- Consult Only (return to referring clinician afterwards)
- Office Visit - to establish speciality care
- Follow-Up
- Surgical
- Other (Please Specify):

I am referring this year old with the following diagnosis(es):

1.
2.

3.

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Medi-Medi
- Other (Please Specify)

CC/HPI of:

Specific Question or Problem you would like the Specialist to Address:

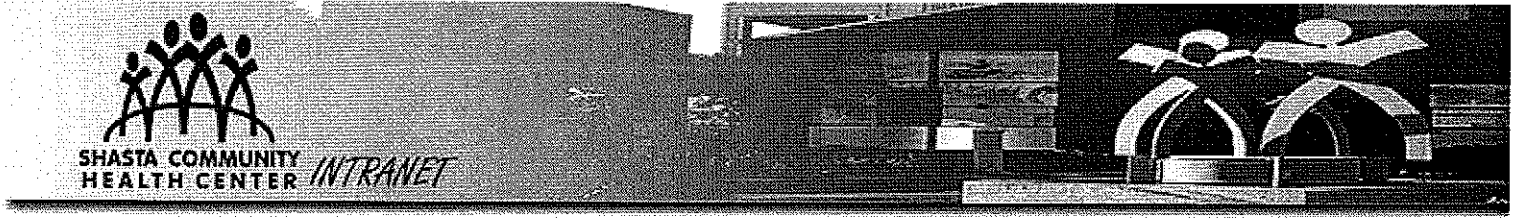
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Plastic Surgery

Specialist:

Please Select

Referring Physician:

Please Select

Parameters for Referral

Referrals where the "Plastics Physician of the day" should be **consulted:**

- Diabetic foot ulcer, Venous stasis ulcers (after all medical attempts have failed)
- Tattoo removal of minors (Dr. Wong Only!)

Inappropriate referrals:

- No Out of Shasta County (South) Referrals
- Cosmetic Requests (if Medi-cal expected to cover)
 - Moles/benign nevi
 - Subcutaneous cysts
- Skin lesions/cancers that have **not** been **biopsied**
- Skin cancer that can be excised easily

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Medi-Medi
- Other (Please Specify)

CC/HPI of:

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Podiatry

Please do not refer nail trimming.
ONCHOMYLOSIS - Requires a positive nail culture, LFT's and Oral Antifungal unless contraindicated.
Contraindications must be documented.

Specialist:

Please Select

Referring Physician:

Please Select

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

- Consult Office Visit Follow-Up
 Telemedicine Work Related
 Other (Please Specify):

I am referring this

year old with the following diagnosis(es):

Please Select

If the diagnosis is Ingrown Toenail, please answer the following questions:

Does the patient have:

An Infection? Yes No

Recurring Infections? Yes No

Avulsions? Yes No

HX % previous

Type of Pain Please Select

Location of Pain:

Have X-rays been done? Yes No

If X-rays have been done, where are they filed?

Does this patient have Diabetes? Yes No

Are there associated complication of PVD or pedal neuropathy? Yes No

Payor Type

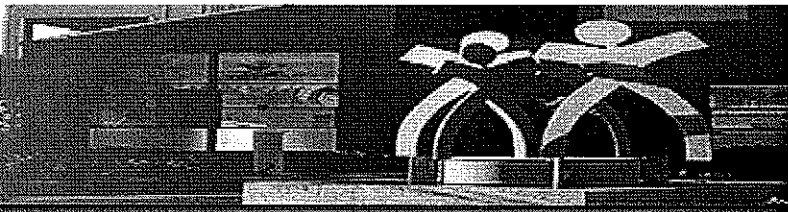
- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- Medi-Medi
- Sliding Fee
- Self Pay
- Private Insurance
- Other (Please Specify)

Specific Question or Problem you would like the Specialist to Address:

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Psychiatry Referral

Referring Physician:

Please Select

STAT or ASAP Parameters:

Clinician to Clinician ONLY!

Is this referral considered "Stat" or "ASAP"?

Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this year old with the following diagnosis(es):

1.

2.

3.

- Consult
- Office Visit
- Follow-Up
- Telemedicine
- Work Related
- Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Medi-Medi
- Other (Please Specify)

CC/HPI of:

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Pulmonary Clinic

Specialist:

Dr. Dayton 

Referring Physician:

Please Select 

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Provisional DX:

In most cases, need recent CXR (PA & LAT), CT-SCAN if indicated.

Films: Previous YES: NO: Studies

Where most Recent?

STAT or ASAP Parameters:

Requires Clinician to Clinician Discussion

Dr. Lupercio 232-3000 Dr. Chang 232-3000 Dr. Dayton 241-5864

Is this referral considered "Stat" or "ASAP"?

Reason for Referral

- Consult Office Visit Follow-Up
- Telemedicine Work Related
- Other (Please Specify):

I am referring this _____ year old _____ with the following diagnosis(es):

1. _____
2. _____
3. _____

Payor Type

- Medi-Cal Medicare CMSP
- EAPC Far Northern Healthy Families
- SOFP/PACT Sliding Fee Self Pay
- Private Insurance Medi-Medi
- Other (Please Specify)

CC/HPI of: _____



Specific Question or Problem you would like the Specialist to Address:

Full Email Address of Person Submitting the Referral:

Pulmonary Nurse: Chris Crowe LVN II Tel: 246-5815 or Ext. 5815

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Rheumatology

Specialist:

Please Select

Referring Physician:

Please Select

PROVISIONAL DIAGNOSIS:

1. Inflammatory Arthritis - Rheumatoid Arthritis, Psoriatic Arthritis, Reiter's Syndrome, Ankylosing Spondylitis
2. Immunological Disorder - Collagen Vascular Disease in Lupus or Scleroderma
3. Metabolic Bone Diseases - Osteoporosis, Paget's Disease

INAPPROPRIATE REFERRALS:

1. Chronic Pain
2. Fibromyalgia
3. Mechanical Spine Pain
4. Chronic Fatigue Syndrome
5. Hepatitis C (Unless CCP Antibody +)

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Clinical Conditions

Required Tests before Consult

Inflammatory Arthritis

Rheumatoid Arthritis
 Psoriatic Arthritis
 Reider's Syndrome
 Ankylosing Spondylitis

RF	Date: 00/00/00	Results:
ANA	Date: 00/00/00	Results:
ESR	Date: 00/00/00	Results:
Uric Acid	Date: 00/00/00	Results:
Hepatitis CAb	Date: 00/00/00	Results:

Immunological Disorder

Collagen Vascular Disease in
 Lupus or Scleroderma

ANA	Date: 00/00/00	Results:
CBC	Date: 00/00/00	Results:
CMET	Date: 00/00/00	Results:
UA	Date: 00/00/00	Results:

Metabolic Bone Diseases

Osteoporosis
 Paget's Disease

DEAX and/or Q CT Scan	Date: 00/00/00	Results:
CMET	Date: 00/00/00	Results:

STAT or ASAP Parameters:
 Suspected Rheumatoid Arthritis
 Systemic Lupus
 Systemic Vasculitis
 May call and schedule via office
 Clinician to Clinician

Is this referral considered "Stat" or "ASAP"?
 (Must meet the above criteria)

Reason for Referral

- Consult
- Office Visit
- Follow-Up
- Telemedicine
- Work Related
- Other (Please Specify):

I am referring this

_____ year old _____ with the following diagnosis(es):

1. _____
2. _____
3. _____

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Medi-Medi
- Other (Please Specify)

CC/HPI of:

Specific Question or Problem you would like the Specialist to Address:

Full Email Address of Person Submitting the Referral:



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- Make A Suggestion!

Sigmoidoscopy

Specialist:

Please Select

Referring Physician:

Please Select

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

- Routine screening Rectal bleeding Diarrhea
- Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Medi-Medi
- Other (Please Specify)

1. Was Occult Blood, Stool, x 2 Done?

- Positive
- Negative
- Pending
- Not Indicated

2. Patient at high risk for colon-rectal cancer?

- Yes
- No

3. Please enter date completed the colon-rectal screening check list:

4. Please enter date performed Rectal Exam

(Not necessarily to be presumed)

Specific Question or Problem you would like the Specialist to Address:

Full Email Address of Person Submitting the Referral:

Submit

Reset Form



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Telemedicine DD Psychiatry - FNRC CONSUMERS ONLY

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Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this

year old

with the following diagnosis(es):

- 1.
- 2.
- 3.

- Consult Office Visit Follow-Up
 Telemedicine Work Related

Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Other (Please Specify)

CC/HPI of:

Specific Question or Problem you would like the Specialist to Address:

Full Email Address of Person Submitting the Referral:

Submit

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Pediatric Neurology Referrals

*** Age 0 - 22 ***

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- Reference Links
- TeleVideo Numbers
- Make A Suggestion!

Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this year old with the following diagnosis(es):

1.
2.
3.

- Consult Office Visit Follow-Up

Telemedicine Work Related

Other (Please Specify):

Payor Type

Medi-Cal Medicare CMSP

EAPC Far Northern Healthy Families

SOFP/PACT Sliding Fee Self Pay

Private Insurance

Other (Please Specify)

CC/HPI of:

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Telemedicine Pediatrics Endocrinology Referrals

*** Under Age 16 ***

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Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this

year old

with the following diagnosis(es):

1.
2.
3.

- Consult Office Visit Follow-Up

- Telemedicine
- Work Related
- Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Other (Please Specify)

CC/HPI of:

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Telemedicine Pediatrics Genetics Referral

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Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this year old with the following diagnosis(es):

1.
2.
3.

- Consult Office Visit Follow-Up
 Telemedicine Work Related

Other (Please Specify):

Payor Type

Medi-Cal

Medicare

CMSP

EAPC

Far Northern

Healthy Families

SOFP/PACT

Sliding Fee

Self Pay

Private Insurance

Other (Please Specify)

CC/HPI of:

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Child Psychiatric Referral

Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this

year old

with the following diagnosis(es):

- 1.
- 2.
- 3.

- Consult Office Visit Follow-Up
- Telemedicine Work Related

Other (Please Specify):
[Text Box]

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Other (Please Specify)
[Text Box]

CC/HPI of:
[Text Box]

Specific Question or Problem you would like the Specialist to Address:
[Text Box]

Full Email Address of Person Submitting the Referral:
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Telemedicine Adult Endocrinology Referral

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Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

- Stat ASAP

Patient Info

First Name:

Middle Name:

Last Name:

DOB:

Medical Record #:

Phone: 530-

Reason for Referral

I am referring this year old with the following diagnosis(es):

1.
2.
3.

- Consult Office Visit Follow-Up
 Telemedicine Work Related

Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
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- EAPC
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- Private Insurance
- Other (Please Specify)

CC/HPI of:

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Telemedicine Adult Psychiatry Referral

No FNRC Consumers

Age 22+ - DDs not FNRC Consumers OK

Referring Physician:

Please Select

STAT or ASAP Parameters:

Is this referral considered "Stat" or "ASAP"?

Stat

ASAP

Patient Info

First

Name:

Middle

Name:

Last

Name:

DOB:

Medical

Record #:

Phone: 530-

Reason for Referral

I am referring this

year old

with the following diagnosis(es):

1.

2.

3.

- Consult
- Office Visit
- Follow-Up
- Telemedicine
- Work Related
- Other (Please Specify):

Payor Type

- Medi-Cal
- Medicare
- CMSP
- EAPC
- Far Northern
- Healthy Families
- SOFP/PACT
- Sliding Fee
- Self Pay
- Private Insurance
- Other (Please Specify)

CC/HPI of:

Specific Question or Problem you would like the Specialist to Address:

Full Email Address of Person Submitting the Referral:

[Return to In-House Referrals](#)