College Park Family Care Center, P.A.

Orthopedic Surgery

2ND OPINION RECORDS TO REVIEW

Please allow 3-5 days for return phone call

Patient name: ____ Date of Birth: _____________

Address: ____ Phone # __________________

Primary Care Physician: ____

How were you referred to our office? ____

What part of the body are you requesting to be seen for? ___________________________________

Are you requesting to be seen for an injury? ________

When and how did the injury occur? ____

Is this a work comp injury? _________ If yes; do you have an attorney representing you?_________

Work Comp Contact information: ____

Who have you seen in the past for this injury or medical issue? ______________________________

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What treatment/testing have you completed thus far ?
Anti-inflammatory meds ______________
Home exercise program ______________
Formal physical therapy ______________
Injections cortisone, etc. ______________
X-rays _____________________________
MRI _______________________________
Other ______________________________

Has surgery been completed on the body part you are requesting a 2nd opinion on? ______________
When was surgery?______________________ Performed by Whom?_________________________
What hospital? ____
(This information will be used to obtain medical records if needed)

Please describe what complaints you have with the body part you are requesting a 2nd opinion on:
(Example: Loss of motion, loss of strength, difficulty sleeping, swelling, etc.)

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MAIL BACK TO: 10600 MASTIN, OVERLAND PARK, KS 66212 or FAX TO: 913-338-1311
Dr. Humphrey