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? _____

_____

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.)

_____

_____

_____

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