



Thank you for choosing to refer your patient to our specialists! To begin the referral process, please complete the form and fax to the specialist of your choice below. We will reach out to the patient to schedule an appointment within 24-48 hours.

PLEASE PROVIDE: Office Notes, Imaging, Medical History, PT History, Medication List

Patient Information					
Patient's (legal) name <i>Last</i>			<i>First</i>	<i>MI</i>	DOB
Patient's Address			City	State	Zip code
Patient's primary phone			Secondary phone		
Preferred Contact Method?	Early Morning	Mid-Morning	Afternoon	Evening	Anytime
Name of Insurance <i>Primary</i>			<i>Secondary</i>		
Referral Information					
Referring Provider			Referring Provider phone		
Reason for Consultation					
General Consultation	Procedure/Surgical Consultation		Rehabilitation	Other _____	
Body Part Affected					
Hip	Knee	Hand	Shoulder	Wrist	Foot Ankle Elbow _____
Diagnosis(ICD-10) or Symptoms					
Appointment Time Frame					
Urgent (24-48 hours)	Within _____ Weeks		Nonurgent	Other: _____	
Physician Specified/ Requested					
Derek Hill, DO ORTHO	First Available Urgent		Michael Peer, PA Physician Assistant	Inpatient Rehabilitation	

Please Send Completed Form To The Department Of Your Choice Below

Derek Hill, DO
Straith Orthopedics
Hip & Knee Specialist
Phone: 248-386-7278
Fax: 248-386-7286

Inpatient Rehabilitation
Allscripts & Epic
Direct Referrals Accepted
Phone: 248-357-3360 Ext: 172
Fax: 248-386-7275