

# REQUEST FOR THERAPY SERVICES

TO: Advanced Orthopaedic Services  
Melissa Stickler (scheduling)

FAX: (770) 664 – 8626

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
(Fax office face sheet and insurance information with this coversheet)

Physician: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Location of Surgery: \_\_\_\_\_

Procedure:	Total knee replacement	Left	Right
	Total knee <u>revision</u>	Left	Right
	<u>UNI</u> knee replacement	Left	Right
	Total hip replacement	Left	Right
	Total hip <u>revision</u>	Left	Right

Other: \_\_\_\_\_

Inpatient Hospital Stay

Outpatient Surgery

23 Hour Stay