Scoliosis Screening Program Referral/Order Form

404-785-7553

Children's℠ Healthcare of Atlanta

To be filled out by
Scoliosis Screening Program
Clinic Site _____
Clinic Date_____

Fill out form and FAX to: 404-785-7576

Date: _____

Patient Name:_____

Date of Birth:_____

Parent/Guardian Name: _____

Parent/Guardian contact phone #_____

Parent/Guardian Primary Language if other than English _____

Diagnosis: - check all that apply

- ☐ **Tertiary Screening for Scoliosis/Kyphosis/Lordosis** (based on findings identified and reported during school screening)
- ☐ **Scoliosis – M41.9 Scoliosis, site unspecified**
- ☐ **Kyphosis – M40.209 Unspecified kyphosis, site unspecified**
- ☐ **Lordosis – M40.56 Lordosis, unspecified, lumbar region**
- ☐ **Other -** _____

_____

Requested X-ray:

- ☐ **Order for X-ray entered in accessCHOA and provide hCG if needed.**
- ☐ **Scoliosis 1 view (72081) and hCG test if needed.**
- ☐ **Scoliosis 2 Views (72082) [if lateral is needed] and hCG test if needed.**

_____

Physician Signature

Physician Name (print)**:** _____

Practice Name:_____

Practice Phone:_____**Practice FAX:**_____