Neurosurgical Consult Request Form

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Date: .....

Name:..... DOB: ..... Age: .....

Social Security #: .....

Phone: .....Other: ....

Address: .....

City: ..... State: ..... ZIP: .....

If this is a patient whom you want seen urgently in addition to this form, please have your physician talk to our doctor.

Our surgeons will only see "second" opinion patients if they wish to transfer care.

Reasons for neurological consult: .....

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Is patient also being sent to another surgeon for this problem? Y N

Has patient been seen by another surgeon? Y N

Has patient had previous neurosurgery? Y N

Industrial injury? Y N Legal case? Y N MVA? Y N

Has the patient been seen in our office before? Y N

If yes, when?.....

If yes, is the patient being seen for the same problem this time? Y N

Authorization Number: .....

Number of Visits: ..... Exp: .....

Referring Physician: .....

UPIN Number: ..... Contact: .....

Phone: ..... Fax: .....

IMPORTANT: PLEASE FAX!

1. A copy of the front and back of the Patient's Insurance Card
2. Authorization or Referral
3. All MRI, CT, EMG/NCV, Myelogram, Plain X-Ray Reports & last three Office Notes

Our office will contact the patient to schedule an appointment. We will return this form to your office with the appointment date/time noted below. Please do not send films prior to the consult. **It is the patient's responsibility to bring their films to the ppointment**. If the patient does not speak English or Spanish, they must bring a translator.

[PLEASE CALL OUR OFFICE FOR ADDITIONAL FORMS]

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