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**Referral Form**

 Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 To process your referral, the following information in required:

**\*\*\*\*\* Patient must have had an MRI within the past 12 months\*\*\*\*\***

* Reason for referral/Chief Complaint:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Copy of insurance cards front & back
* Worker’s Comp. or Third party information, if applicable
* Physical Therapy notes
* Imaging reports (MRI, CT scans, x-rays) related to the referral. **Patient will need to bring images to appointment if done outside of Schneck**
* Recent office notes

Is patient on Opioids? 🞎 Yes 🞎 No

Has the patient ever had spine surgery?

🞎 Yes 🞎 No

If yes: Surgeon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the patient consulted with another orthopedic/neurosurgeon regarding the same chief complaint?

🞎 Yes 🞎 No

If yes: Surgeon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fax all information to 812-523-4752**

**Phone: 812-523-7870**