FastTrac™
Provided by NeuroSpine

NEW PATIENT REFERRAL FORM

PATIENT INFORMATION *All Patient information is required to prevent any delays in scheduling.*

Name:______________________________ DOB: __________ SS#: ________________

Mailing Address: ____

Home Phone: __________________________ Cell: ___________________________

Chief Complaint:______________________________________ Urgent Referral? ☐ Yes ☐ No

☐ NEUROSURGERY

☐ First Available ☐ Dr. Catherine J. Gallo
☐ Dr. Christopher G. Miller ☐ Dr. Carmina F. Angeles

☐ PAIN MANAGMENT

☐ First Available ☐ Dr. Gregory M. Phillips
☐ Dr. Gregory A. Moore

MRI IMAGING IS REQUIRED FOR ALL NEUROSURGERY REFERRALS

IMAGING STUDIES (Studies must have been taken within the last 12 months.)

☐ **Schedule MRI at NeuroSpine Imaging** (Please include FastTrac Packet and Chart Notes)

To schedule an appointment, please fax FastTrac Packet to (541) 686-3793

☐ **Have current imaging studies available**

MRI Date performed:________________ Facility:________________________________

CT Date performed:________________ Facility:________________________________

X-RAY Date performed:________________ Facility:________________________________

REFERRING PROVIDER

Physician:____________________________ PCP:____________________________

Phone:____________________________ Phone:____________________________

WORKER'S COMPENSATION INJURY, MVA OR OTHER LIABILITY

Company:____________________________ DOI:____________________________

Adjuster's Name:________________________ Phone:________________________

MEDICAL HEALTH INSURANCE IS REQUIRED WITH ANY WC OR MVA REFERRAL

Health Insurance Company:__________________________________ ID # ______________

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IMAGING ORDER FORM

Please Fax to 541-686-3793

Ordering Physician: ______________________ Phone: ______________ Fax: ________________

Ordering: ☐ MRI ☐ CT ☐ X-Ray ☐ W/Contrast ☐ W/O Contrast | Imaging Area: ☐ Cervical ☐ Thoracic ☐ Lumbar

Diagnosis / ICD-10: ____

Notes: ____

*** * * Form must be complete and faxed with IMAGING ORDER and CHART NOTES * * ***

PATIENT INFORMATION

______	______	______	___/___/___	______	______
First Name	Middle Initial	Last Name	Date Of Birth	Weight	Height

INSURANCE INFORMATION

Primary Insurance: ______________________ Policy: ______________ ID: ________________

PATIENT SYMPTOMS/TREATMENT

What are the patient's symptoms? ____

☐ Radicular Pain ☐ Numbness ☐ Weakness **How Long have the symptoms been present?**

Has the patient tried conservative treatment? ☐ Yes ☐ No. **If yes, when did it start and end?**

☐ Physical Therapy ☐ Chiropractic ☐ Other

____

____

____

** If Physical Therapy was part of your treatment, please include records with this order.*

MEDICATIONS

Has the patient been prescribed any medication for this condition? ☐ Yes ☐ No. **If yes, what and when?**

____

____

____

PREVIOUS IMAGING

Has the patient had any previous imaging? ☐ Yes ☐ No. **If yes, check which ones apply.**

☐ **MRI** Where: ______________________________ Date: ______________

☐ **CT** Where: ______________________________ Date: ______________

☐ **X-Ray** Where: ______________________________ Date: ______________

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______________________________ ______________________________

Ordering Physician Name Physician Signature

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IMAGING SAFETY SCREENING

Please Fax to **541-686-3793**

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH ____/____/____	PROCEDURE

WEIGHT: __________ HEIGHT: ___________

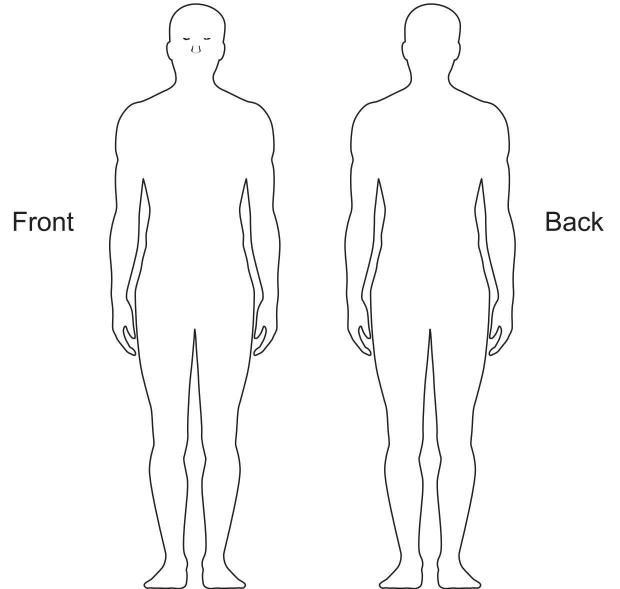
Briefly describe current symptoms and when they first occurred:
____
____

List all other tests you have had for this part of your body:
____
____

List any surgery you have had for this part of your body:

What: ______________________When: ___________________
Where:____

Patient is 60 or older? ☐ Yes ☐ No | Diabetic? ☐ Yes ☐ No
Patient on Dialysis? ☐ Yes ☐ No
History of renal diseases, failures or transplants? ☐ Yes ☐ No



ON THE ABOVE DIAGRAM, PLEASE SHADE IN ALL AREAS WHICH ARE AFFECTED BY YOUR CURRENT PROBLEM.

The following items can interfere with MRI imaging and some may be hazardous to your safety.

PLEASE CIRCLE THE FOLLOWING:

Item		
Pacemaker / Defibrillator	Y	N
Brain Chip	Y	N
Impanted Pump	Y	N
Neurotransmitter (Tens Unit)	Y	N
Hearing Aid / Ear Implant	Y	N
Eye Implant / Artificial Eye	Y	N
Heart Value	Y	N
Coil / Filter / Stent	Y	N
Patch on Skin for Medication	Y	N
Any Rods, Screws, Pins in Bones	Y	N
Penile Implant	Y	N
Artificial Joint / Limb	Y	N
Have you ever been a Metal Worker?	Y	N
Have you been treated for Metal in the face or eyes?	Y	N
Bullet / Shrapnel	Y	N
Dentures / Dental Implant	Y	N
Body Piercing	Y	N
Location of Body Piercing:		

Item		
Swan - Ganz Catheter	Y	N
Vascular Access Portal	Y	N
Any Magnetic Implant	Y	N
Any personal history of cancer	Y	N
Type of Cancer:		
Are you Diabetic	Y	N
Do you have Sickle Cell Anemia?	Y	N
Any Kidney Disease	Y	N
Any Liver Disease (Hepatitis)	Y	N
Any Blood Disorders	Y	N
Allergies:	Y	N
Claustrophobic	Y	N
FOR WOMEN ONLY		
Are you pregnant?	Y	N
Are you Breast Feeding?	Y	N
I.U.D. or Diaphragm?	Y	N
Any Breast Tissue Expander?	Y	N
Date of Last Menstrual Period?		

______________________ ________ ______________________
Signature of Patient Date Signature of Parent or Guardian

TECH NOTES:

____
Technologist Confirmation Date

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