NeuroSpine

REFERRAL FORM

Fax to 541-686-3795

ALL Patient Information is required to prevent delays in scheduling.

REFFERING PROVIDER

Referring Physician:______________________________ PCP:______________________________

Phone:______________________________ Fax:______________________________

Chief Complaint: ______________________________ Urgent Referral? ☐ Yes ☐ No

☐ First Available ☐ Dr. Catherine J. Gallo ☐ Dr. Christopher G. Miller

PATIENT INFORMATION

Patient Name:______________________________ DOB: ____________ Last 4 of SSN: ____________

Mailing Address: ______________________________ City: ____________ State: _____ Zip: ________

Home Phone: ______________________________ Cell/Other: ______________________________

INSURANCE

Insurance Company: ______________________ Subscriber ID: ________________ Group#: __________

☐ Worker's Comp (DOI: ____________) ☐ MVA (DOI: ____________) Case #: ________________

Adjusters Name (If Workers Comp or MVA): ______________________ Phone: ____________________

IMAGING STUDIES (Referral MUST come with MRI/CT within 12 months)

MRI:
Part of Body: ________________ Date performed: ________________ Facility: ________________

CT:
Part of Body: ________________ Date performed: ________________ Facility: ________________

XRays:
Part of Body: ________________ Date performed: ________________ Facility: ________________

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