REFERRAL FORM

Patient Name: _____ DOB: _____ Date: _____

First Available ☐
Dr. Campbell ☐
Dr. Louis ☐
Dr. Schermerhorn ☐

Prior Authorization is required for Priority Health, Tricare, and Molina
Authorization number: _____

This consult request is regarding the following problem:

Brain:
- ☐ Brain Tumor
- ☐ Trauma
- ☐ Seizure
- ☐ Other: _____

Spine:
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Radiculopathy
- ☐ Myelopathy
- ☐ Trauma
- ☐ Tumor
- ☐ Bone Stimulator

Musculoskeletal:
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Elbow/Wrist
- ☐ Ankle/Knee

Neurological:
- ☐ Loss of Bowel/Bladder
- ☐ Foot Drop
- ☐ Weakness
- ☐ Sensory Loss/Numbness
- ☐ Nerve Injury/Damage
- ☐ Other_____

Please include the following – We cannot schedule without these documents:

_____DEMOGRAPHIC FACE SHEET/COPY OF INSURANCE CARDS

_____ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.) – **MRI REQUIRED WITHIN 6 MONTHS**

_____MOST RECENT PHYSICIAN'S NOTES

_____PREVIOUS NEUROSURGERY NOTES

PLEASE FAX TO **(231)392-0643**