Salem Health Spine Center

Referral Form

Salem Health® Hospitals & Clinics

Today's Date: _____ **Referring Provider:** _____

Office Contact Person: _____ **Phone:** _____

Primary PCP: _____

Specific Neurosurgeon? ☐ Yes ☐ No

If yes: ☐ Collada ☐ Nanaszko ☐ Hatchette ☐ Kafka ☐ Gahramanov

Patient must have a spine level MRI with in the last 12 months

Patient information

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Patient symptoms and/or diagnosis: _____

Current Related Studies (Must be in the last 12 months)

☐ MRI When: _____ Where: _____

☐ CT When: _____ Where: _____

☐ XRAYS When: _____ Where: _____

☐ EMG/NCV When: _____ Where: _____

☐ Bone Scan When: _____ Where: _____

Insurance information

Primary Insurance: _____

ID#: _____ Group #: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Work Injury: ☐ Yes ☐ No _____ MVA: ☐ Yes ☐ No _____

Work Comp Carrier Insurance

Claim #: _____ Date of Injury: _____

FAX TO: 503-814-5495

salemspinecenter.org

Salem Health Spine Center
P.O. Box 14001
Salem, OR 97309-5014

Phone: 503-814-BACK (2225)
Toll Free: 1-866-944-2224
Fax: 503-814-5495

DSC436434(2/17)