

# Salem Health Spine Center

## Referral Form



Today's Date: \_\_\_\_\_ Referring Practitioner: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary PCP: \_\_\_\_\_

Specific Neurosurgeon?  Yes  No

If yes:  Collada  Gahramanov  Hatchette  Nanaszko  York

If NO MRI completed would you like physiatry review?  Yes  No

If yes:  Blake  Brumbaugh  Hook  Truong  Rotation

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Patient symptoms and/or diagnosis: \_\_\_\_\_

### CURRENT RELATED STUDIES

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**