

Consultation Request Form

Date: _____

Patient Name: _____

SS# _____ DOB: _____

Address: _____

Home # _____ Mobile # _____ Work # _____

Requesting Physician: _____ **Physician's NPI#** _____

UPIN # _____ Medicaid # if applicable _____ **Practice's NPI#** _____

Practice name & Address: _____

Contact Person: _____ Phone# _____

****Please follow up with us via phone call if we haven't notified you of consultation appointment time/date within 48 hours****

Specific Physician Requested: _____ or First Available _____

Office Location Preference: Greensboro Burlington High Point First Available

Has patient been seen by us before? _____ If so, when? _____ Dr. _____

Reason For Consultation: _____

Prior intracranial or spinal surgery? _____ When? _____

Imaging studies performed? _____ none

_____ yes ****attach results & have patient bring original films to appointment****

Please include with this fax: _____ Reports of any imaging studies
_____ Treatment records pertaining to this problem
_____ Insurance card or worker's comp info if applicable
_____ Insurance authorization/referrals, if needed

Requesting Physician Signature: _____