CULLMAN REGIONAL | Medical Group

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SPINE SPECIALIST REFERRAL FORM

Patient name _____ DOB _____

Phone _____ Cell _____

Address _____

_____

Height _____ Weight _____

Insurance _____ Policy # _____

Referral authorization # if required _____

No workup required to refer a patient but please indicate which tests have already been completed.

COMPLETED TEST (SELECT ONE)

- ☐ X-ray
- ☐ CT/Myelogram
- ☐ Bone Density
- ☐ MRI
- ☐ NCS/EMG

DIAGNOSIS/INDICATIONS

- ☐ Cervical Pain
- ☐ Radiculopathy
- ☐ Stenosis
- ☐ Thoracic Pain
- ☐ Numbness
- ☐ Disc Herniation
- ☐ Lumbar Pain
- ☐ Paresthesia
- ☐ DDD
- ☐ Work-related injury
- ☐ Motor vehicle accident

Other # _____ Allergies _____

ORDERING PROVIDER

Physician _____

Phone # _____ Fax # _____

Physician signature _____

Appointment Date/time _____ Patient notified on _____

Physician will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures.