NEUROSURGICAL ASSOCIATES NEW PATIENT REFERRAL

Rex Arendall, MD
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Ph: 615-986-1256
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Thank you for referring your patient to our office. In order to process your referral, please complete **ALL** of the requested information on this form and fax to our office along with the information listed below. Once your fax is received, Dr. Arendall will personally review your patient's information and determine if he can evaluate the patient for surgery. Our office will contact you with an appointment.

Please Attach:
-Current Office Notes from ALL Treating Physicians, Including Specialists
- Imaging Reports (MRI, CT, X-rays & EMG)
-Operative Note(s)
-Copy of Insurance Card(s)

REFERRING PHYSICIAN NAME_____ CONTACT NAME_____

ADDRESS_____ PHONE # (____)_____ FAX # (____)_____

PATIENT NAME _____ M F DOB _____ SSN _____

ADDRESS _____ ZIP CODE_____

DIAGNOSIS _____ PREVIOUS FILMS? _____ PHONE # (____)_____ ALT # (____)_____

PRIMARY INS:_____ PPO HMO POLICY # _____

SECONDARY INS: _____PPO HMO POLICY # _____

REFERRAL REQUIRED FOR SPECIALIST VISIT? YES NO IF YES, WILL YOUR OFFICE FAX? _____

INJURY RESULT OF MVA? YES NO

WORKERS COMP? YES NO

IN LITIGATION? YES NO

HAS PATIENT HAD SURGERY IN THE PAST 2 YEARS FOR THIS CONDITION? YES NO

We are committed to providing efficient and prompt service. If you do not receive a response regarding this patient within 72 hours of your faxed request, please contact our office at (615) 986-1256.

NEUROSURGICAL ASSOCIATES INTERNAL USE ONLY:

Approved by Dr. Arendall/Notes:	
Appt. date & time: _____	**Benefits Verified: _____**
Referring Ofc. Notification date & method:_____	**Patient Notification Notes:_____**