NEUROSURGICAL ASSOCIATES NEW PATIENT REFERRAL

Thank you for referring your patient to our office. Please complete **ALL** of the requested information on this form and fax to the number listed below along with current office notes, imaging reports (such as MRI, CT, X-rays & EMG), insurance information and any additional information the referring physician feels necessary. To ensure efficient and prompt treatment, it is imperative that each patient bring their recent imaging films and/or discs to their scheduled appointment. Once our office has scheduled an appointment for the patient, we will promptly fax or call your office with that information.

Please indicate the desired location:

Dr. William R. Schooley
Fax #: 615-320-4106

___1642 Westgate Circle, Ste. 201
Brentwood, TN 37027

___Centennial Professional Plaza
345 23rd Avenue North, Suite 320
Nashville, TN 37203

___40 W. Caldwell St., Ste. 201
Mt. Juliet, TN 37122

___515 Stonecrest Pkwy., Ste. 200
Smyrna, TN 37167

___ 1547 Warrior Drive, Suite B
Murfreesboro, TN 37128

REFERRING PHYSICIAN NAME_____ **CONTACT** _____

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? _____

IS THIS INJURY RELATED TO: WORK COMP? _____ **MOTOR VEHICLE ACCIDENT?** _____

We are committed to providing efficient and prompt service. If you do not receive an appointment for this patient within 24 hours of your faxed request, please contact our office at (615) 986-1256.

NEUROSURGICAL ASSOCIATES INTERNAL USE ONLY:

Appt. date, time & location: _____	**Benefits Verified:** _____
Referring Ofc. Notification date & method:_____	**Patient Notification Notes:**_____