3533 Southern Blvd., Suite 3000, Kettering, OH 45429
Phone (937) 299-8242 Fax (937) 299-8245
www.advancedneurosurg.com

PHYSICIAN REFERRAL FAX FORM

Patient's Name:_____

Date of Birth: _____ SSN#:_____ Male/Female

Address:_____

_____

EMAIL: _____
(Please mark preferred phone#)
☐Home phone#_____
☐Work Phone# _____
☐Cellphone# _____

Referring Physician: _____ Phone#_____
NPI#_____
Contact Person: _____ Fax # _____

Family Physician:_____ Phone# _____

Insurance: Primary _____ ****ATTACH COPY OF INSURANCE CARD(s)****

Secondary_____

****IF BWC? C-9 APPROVAL MUST BE ATTACHED**

DIAGNOSIS _____

TESTING: (Please attach ALL Testing Reports)
_____ MRI (If not done – why? i.e. Metal in the body, pacemaker)
_____ CT SCAN
_____ EMG
_____ X-rays
_____ No testing done Why?_____

ANY PREVIOUS SURGERY (for this current problem area) ?? If Yes – please attach the previous surgery reports – If your office does not have access to these – Please have the member contact the surgeon's office or hospital to fax these to our office.