



Spine Surgery Consult Form Community Health Network

Referring Doctor: _____
Contact Number: _____
Fax Number: _____

Patient Demographics & Contact Information

Name _____
Address _____
Home Phone _____
Cell Phone _____
Work Phone _____
E-mail Address _____

Reason for referral: _____

Diagnosis: _____

Patient Insurance Information

Company _____
Name of Subscriber _____
Subscriber Date of Birth _____

Please fax a copy of the front and back of the insurance card.

Worker's Comp? YES NO
Motor Vehicle Accident? YES NO
Previous Back Surgery? YES NO

If prior back surgery, please fax a copy of the office notes and surgery summary.

Diagnostic Tests

MRI YES NO
EMG YES NO
CT SCAN YES NO
X-RAYS YES NO

Please inform patients they need to bring their **original** films.

Physician Contact Information

Preferred method of receiving patient's clinical notes:

- E-mail: _____ *please print e-mail address*
- Fax:
- Mail:

Other Comments / Patient Notes: _____

Patient Scheduled

Date: _____
Time: _____
Scheduler: _____
Patient Notified? YES NO

**Please fax the completed surgery consult form, pertinent medical records and patient's insurance form to (317) 577-0619.
If you have any questions, please call (317) 228-7000.**

Thank you for your referral!

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