



Patient Referral Form Carmel / Indianapolis Offices

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

Patient Demographics & Contact Information

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

Patient Insurance Information

Company _____
Address _____
Name of Subscriber _____
Subscriber Date of Birth _____
Subscriber ID/SS# _____
Phone Number _____
Referral Authorization _____
Contact Person _____
Phone Number _____

Previous Back Surgery? YES NO

Worker's Comp? YES NO

Motor Vehicle Accident? YES NO

Please note that we are not a Medicaid provider.

13225 N. Meridian St. | Carmel, IN 46032

Spine Surgery

Please fax referral form to (317) 715-4887.

- Dr. Rick Sasso
- Dr. Kenneth Renkens

Spinal Diagnostics & Therapeutics

Please fax referral form to (317) 715-5895.

- Dr. Kevin Macadaeg
- Dr. John Arbuckle

8040 Clearvista Parkway, Suite 440 | Indpls, IN 46256

Please fax referral form to (317) 577-0619.

- Dr. Jonathan Gentile | **Spinal Diagnostics & Therapeutics**
- Dr. Paul Kraemer | **Spine Surgery**

Reason for referral: _____

Diagnosis: _____

Consultation YES NO

Injection YES NO

- GREATER OCCIPITAL NERVE BLK
- EPIDURAL (CER, THOR, LUMB)
- SELECTIVE NERVE ROOT (CER, THOR, LUMB) – EXCEPT C1-2
- FACET JOINT (CER, THOR, LUMB)- EXCEPT C1-2
- TENDON SHEATH
- SI JOINT
- HIP (BURSA AND JOINT)
- PERIPHERAL NERVE BLK
- INTERCOSTAL NERVE BLK
- TRIGGER POINT
- PIRIFORMIS
- ILIOINGUINAL/ILIOHYPOGASTRIC
- OTHER, please specify _____

MRI YES NO

EMG YES NO

CT SCAN YES NO

X-RAYS YES NO

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

Patient Scheduled

Date: _____

Time: _____

Physician: _____

Scheduler: _____

Patient Notified? YES NO

Priority Referral YES NO

Please schedule my patient with the first available appointment.

To expedite the scheduling process, you may fax over your patient's demographic information and insurance cards. We will call your patient and schedule their appointment. We will then fax the appointment date and time to your office. **Thank you!**

Please fax patient referral form to the phone numbers as listed above.

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