Patient Referral Form

Kokomo Office

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 ______
Name of Subscriber ______
Subscriber Date of Birth ______
Please fax a copy of the front and back of the insurance card.

Please Refer My Patient To:

- ❍ **Thomas M. Reilly, M.D., F.A.C.S. | Spine Surgery**
- ❍ **John W. Arbuckle, M.D. | Spinal Diagnostics & Therapeutics**
- ❍ **Jonathan P. Gentile, M.D. | Spinal Diagnostics & Therapeutics**

Reason for referral: ______

Diagnosis: ______

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.*

Other Comments / Patient Notes: ______

Patient Scheduled
Date: ______
Time: ______
Scheduler: ______
Patient Notified? ❍ **YES** ❍ **NO**

Please fax the completed referral form, pertinent medical records and patient's insurance form to (756) 236-8705. We will call your patient and schedule their appointment. We will then fax the appointment date and time to your office. If you have any questions, please call (765) 236-8700.

Thank you for your referral!

Indiana Spine Group
307 South Berkley Road | Kokomo, Indiana 46901

www.indianaspinegroup.com