



**NEUROSURGICAL/
INTERVENTIONAL PAIN MANAGEMENT
CONSULTATION REQUEST**

Phone: (317) 396-1199

Date: _____

Referral Source Information:

Referring Doctor: _____ Phone: () _____ - _____

Office Contact: _____ Fax: () _____ - _____

Requested Goodman Campbell Doctor: (Please Circle Preferred Physician or First available)

_____ *Neurosurgical Consultation*

- | | | | |
|---|---------------------------------|----------------------------------|--|
| <i>Dr. Laurie Ackerman (peds at Riley only)</i> | <i>Dr. Eric Horn</i> | <i>Dr. Paul Nelson</i> | <i>Dr. Jodi Smith (peds at Riley only)</i> |
| <i>Dr. Joel Boaz (peds at Riley only)</i> | <i>Dr. Steven James</i> | <i>Dr. Troy Payner</i> | <i>Dr. W. James Thoman</i> |
| <i>Dr. James Callahan</i> | <i>Dr. Saad Khairi</i> | <i>Dr. Eric Potts</i> | <i>Dr. Michael Turner</i> |
| <i>Dr. Aaron Cohen-Gadol</i> | <i>Dr. Thomas Leipzig</i> | <i>Dr. Michael Pritz</i> | <i>Dr. Thomas Witt</i> |
| <i>Dr. Jeffrey Crecelius</i> | <i>Dr. Shannon McCanna</i> | <i>Dr. Richard (Ben) Rodgers</i> | <i>Dr. Robert Worth</i> |
| <i>Dr. Daniel Fulkerson</i> | <i>Dr. Itay Melamed</i> | <i>Dr. Carl Sartorius</i> | <i>Dr. Ronald Young</i> |
| <i>Dr. Randy Gehring</i> | <i>Dr. James Miller</i> | <i>Dr. Mitesh Shah</i> | First Available |
| <i>Dr. Peter Gianaris</i> | <i>Dr. Jean-Pierre Mobasser</i> | <i>Dr. Scott Shapiro</i> | |

_____ *Pain Management Consultation*

- | | |
|------------------------------|--------------------------|
| <i>Dr. Christopher Doran</i> | <i>Dr. Jose Vitto</i> |
| <i>Dr. Anthony Sabatino</i> | <i>Dr. Derron Wilson</i> |

First Available

Patient Information:

Legal Name: _____ M.I. _____ D.O.B. _____ - _____ - _____

Home Address: _____ S.S. # _____ - _____ - _____

City / State / Zip: _____

Home Phone: () _____ - _____ Work Phone:() _____ - _____ Cell Phone:() _____ - _____

Diagnosis/Symptoms:

Prior Testing / Surgery (Type, When, Where):

Insurance Information:

Company Name : _____

Policy Holder Name: _____

Policy Type / Name: _____

Policy #: _____

Precertification Required: Yes / No

Please fax with this sheet the following information:

- Patient Demographic Information
- Radiology Reports
- Doctors Office Notes
- Procedure Notes
- Insurance Card Copy
- Labs (if applicable)

Please fax to: (317) 396-1443