



**GOODMAN CAMPBELL**  
BRAIN AND SPINE

**Please fax this sheet to (317) 396-1443 with the following information:**

- |  |   |
|--|---|
| <input type="checkbox"/> Patient Demographic Information | <input type="checkbox"/> Radiology Reports    |
| <input type="checkbox"/> Doctors Office Notes            | <input type="checkbox"/> Procedure Notes      |
| <input type="checkbox"/> Insurance Card Copy             | <input type="checkbox"/> Labs (if applicable) |

**NEUROSURGICAL/INTERVENTIONAL PAIN MANAGEMENT CONSULTATION REQUEST**

DIRECT SCHEDULING LINE: (317) 396-1199

Date: \_\_\_\_\_

**Referral Source Information**

Referring Doctor: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Office Contact: \_\_\_\_\_ Fax: (     ) \_\_\_\_\_ - \_\_\_\_\_

**Requested Goodman Campbell physician** (circle preferred physician or "First Available")

\_\_\_\_\_ Neurosurgical consultation

First available

Dr. Laurie Ackerman (peds at Riley only)

Dr. Nicholas Barbaro

Dr. Joel Boaz (peds at Riley only)

Dr. Jamie Bradbury

Dr. James Callahan

Dr. Aaron Cohen-Gadol

Dr. Jeffrey Crecelius (Lafayette only)

Dr. Daniel Fulkerson

Dr. Randy Gehring (Lafayette only)

Dr. Peter Gianaris

Dr. Eric Horn

Dr. Steven James

Dr. Saad Khairi

Dr. Thomas Leipzig

Dr. Shannon McCanna

Dr. James Miller

Dr. Jean-Pierre Mobasser

Dr. Troy Payner

Dr. Eric Potts

Dr. Michael Pritz

Dr. Richard (Ben) Rodgers

Dr. Carl Sartorius

Dr. Mitesh Shah

Dr. Scott Shapiro

Dr. Jodi Smith (peds at Riley only)

Dr. Michael Turner

Dr. Thomas Witt

Dr. Ronald Young

\_\_\_\_\_ Pain management consultation

First available

Dr. Christopher Doran

Dr. Anthony Sabatino

Dr. Jose Vitto

Dr. Derron Wilson

**Patient Information**

Legal Name: \_\_\_\_\_ M.I. \_\_\_\_\_ D.O.B. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Work: (     ) \_\_\_\_\_ - \_\_\_\_\_ Cell: (     ) \_\_\_\_\_ - \_\_\_\_\_

Has the patient seen a surgeon / pain MD / neurologist in the past two years? **Yes No** If yes, list date(s) and providers:

Has patient ever had spine surgery? **Yes No** If yes give date and surgeon name: \_\_\_\_\_

Has patient been seen in an ER recently? **Yes No** If yes, which hospital? \_\_\_\_\_

**Diagnosis/Symptoms:**

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

Check all that apply     Plain film     MRI     CT     Angiogram     Myelogram     EMG

**Insurance Information:**

Company Name: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Type / Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Precert Required: Yes / No