GOODMAN CAMPBELL
BRAIN AND SPINE

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NEUROSURGICAL AND INTERVENTIONAL PAIN MANAGEMENT CONSULTATION REQUEST

Patient Name: _____ Date of Birth: _____

To Expedite Your Referral, It Is Critical to Provide the Following Information:

Reason for Referral / Chief Complaint: _____

1) **Patient Demographic Sheet**
2) ***Most Recent*** **MRI/CT Report**
3) **Copy of Insurance Card(s)**
4) ***Most Recent*** **Office Visit Note**
5) **Physical Therapy Notes (within the past 1 year)**

☐ **Please check if the patient has not had any diagnostic testing.**

Has the patient ever had Spine Surgery? If Yes: Date: _____

☐ Yes ☐ No Surgeon: _____

Has the patient consulted with another orthopedic/neurosurgeon regarding the same chief complaint?

☐ Yes ☐ No If Yes: Date: _____

Surgeon: _____

REQUESTED GCBS PHYSICIAN NAME: _____ OR

☐ First Available Neurosurgeon ☐ First Available Pain Management Physician ☐ Physiatry

LOCATION PREFERENCE

☐ No Preference / First Available	☐ IU Health East	☐ Lafayette
☐ Bloomington	☐ IU Health North	☐ Lebanon
☐ Eskenazi	☐ IU Health Saxony	☐ Muncie
☐ Greenwood	☐ IU Health West	☐ St. Vincent Fishers
☐ Goodman Hall / Methodist	☐ IU Riley	☐ St. Vincent 86th Street

REFERRAL SOURCE INFORMATION Date: _____

Referring Doctor Name: _____ Phone: ( ) _____-_____

Office Contact: _____ Fax: ( ) _____- _____

PLEASE FAX THIS COMPLETED FORM AND ALL REQUESTED INFORMATION TO:

Indianapolis: 317-396-1443 | **Bloomington**: 812-822-1467 | **Lafayette**: 765-447-4172

Muncie: 765-282-7879 | **Riley:** 317-274-8895