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) **Copy of Insurance Card(s)**
3) ***Most Recent* MRI/CT Report**
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?

☐ Yes ☐ No

If Yes: Date: ____________________

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

LOCATION PREFERENCE

☐ No Preference / First Available ☐ Carmel ☐ St. Vincent Fishers

☐ Avon ☐ Greenwood ☐ St. Vincent 86th Street *(Pediatrics Only)*

REFERRAL SOURCE INFORMATION

Date: _________________

Referring Doctor Name: _________________________________ Phone: ( ) ______-___________

Office Contact: ____ Fax: ( ) _______- __________

Ability for office to send an Electronic Summary of Care / CCDA: ☐ YES ☐ NO

PLEASE FAX THIS COMPLETED FORM AND ALL REQUESTED INFORMATION TO:

Indianapolis: 317-396-1443 | Greenwood: 317-396-1419

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