

Consultation Request

Patient name: _____ Date of birth: _____

Phone number: _____

To expedite your referral, it is critical to provide the following information:

Reason for referral/ chief complaint: _____

- | | |
|-------------------------------------|--|
| 1. Patient demographic sheet | 4. Most recent office visit note |
| 2. Copy of insurance card(s) | 5. Physical therapy notes (within the past 1 year) |
| 3. Most recent MRI/CT report | 6. Interventional pain management notes (if available) |

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

Is this a workers' compensation case?

Yes No

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 physicianFirst available interventional
neuroradiologist**Location preference**

No preference / First available

Pediatric Neurosurgery at Peyton Manning
Children's Hospital

Avon

Carmel

Columbus

Greensburg

Greenwood

Indianapolis

Mooresville

Noblesville

Referral source information

Referring doctor name: _____ Date: _____

Office contact: _____

Phone: _____ Fax: _____

Ability for office to send an electronic summary of care/CCDA Yes No

Please fax this completed form and all requested information to: **(317) 396-1443**