Date of Appt. _____

CONSULT REQUEST

Your Initials _____

Requesting Doctor Information

Requesting Doctor name: _____

Date: _____ Time: _____ Person calling: _____

Phone: _____ Fax: _____ NPI _____

Patient Information

Name: _____ DOB: _____

Address: _____ SSN: _____

Phone: _____ _____ _____

Home Work Cell

Insurance: _____ ☐ Male ☐ Female

Reason for visit:

_____

Has the patient had any previous neurological surgery? ☐ Yes ☐ No

If yes, which doctor? _____

Which of the following tests or treatments have been completed?

- ☐ MRI of _____
- ☐ CT of _____
- ☐ Myelogram of _____
- ☐ EMG/NCV of _____
- ☐ Bone scan of _____
- ☐ MRA of _____
- ☐ CTA of _____
- ☐ Bracing
- ☐ Physical Therapy
- ☐ NSAIDs
- ☐ Muscle Relaxers
- ☐ Pain Medications
- ☐ Lumbar Epidural Injection
- ☐ Trigger Point Injection
- ☐ Selective Nerve Root Block
- ☐ Medrol Dose Pack
- ☐ Other _____

Is this exam due to a work related injury?

_____

Is this exam due to a motor vehicle accident?

_____