NEUROSURGICAL CONSULTATION REFERRAL FORM

To facilitate an appointment with **DR. JONATHAN T. PAINE**, kindly **provide** any **Film Reports, Lab Results, Most Recent Office Notes, or other studies** relating to the diagnosis.

Please complete in its entirety and fax back to: **(321)-952-0163**
If you have any questions call: (321)-727-2468
If Medicare patient, does referring doctor have an enrollment record in PECOS?
YES / NO
(Mandatory for all Medicare referrals after 1/2/11)

Date of Referral: ______________________ Diagnosis: ______________________________

Patient Name: _________________________ DOB: ________________

Patient Address: ____
(Street City and Zip)

Home #: __________________ Cell #: _________________ Work #: _______________

Referring Dr/Facility_________________________________

Phone #: ________________________ Fax #: ________________________

Referring Dr's N.P.I.: ________________________________

Contact Person: _____________________________ Ext: _________________________

(PLEASE FAX FRONT AND BACK OF INSURANCE CARDS)

Primary Ins: _________________________ Ins Phone #: _________________________

Secondary Ins: _______________________ Ins Phone #: _________________________

(Please *circle* Patient's type of Insurance below)

HMO, POS, PPO, MEDICARE, AUTO, SELF-PAY, OTHER

Work Injury: YES / NO Auto Accident: YES / NO

Work Comp. Adjuster: ______________________ Date of Accident or Injury: _______________

Authorization # (if required): ___________________ # of visits Authorized: _______________

Authorization Expiration Date: ________________

COMMENTS:____

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Our office will notify you of patient's appointment via a fax transmittal.