Salem Health Spine Center

Referral Form

Today's Date: ______________ **Referring Practitioner:** ______________

Office Contact Person: ______________ **Phone:** ______________

Primary PCP: ______________

Specific Neurosurgeon? ☐ Yes ☐ No

If yes: ☐ Collada ☐ Gahramanov ☐ Hatchette ☐ Nanaszko

If *NO MRI* completed would you like physiatry review? ☐ Yes ☐ No

If yes: ☐ Blake ☐ Brumbaugh ☐ Hook ☐ Truong ☐ Rotation

PATIENT INFORMATION

Patient Name: ______________ DOB: ______________ ☐ Male ☐ Female

Address: ______________

City: ______________ State: ______________ Zip: ______________

Home #: ______________ Cell #: ______________ Work #: ______________

Patient symptoms and/or diagnosis: ______________

CURRENT RELATED STUDIES

☐ MRI When: ______________ Where: ______________

☐ CT When: ______________ Where: ______________

☐ XRAYS When: ______________ Where: ______________

☐ EMG/NCV When: ______________ Where: ______________

☐ BONE SCAN When: ______________ Where: ______________

INSURANCE INFORMATION

Primary Insurance: ______________

ID#: ______________ Group #: ______________

Secondary Insurance: ______________

ID#: ______________ Group #: ______________

Work Injury: ☐ Yes ☐ No ______________ MVA: ☐ Yes ☐ No ______________

Work Comp Carrier — Insurance

Claim #: ______________ Date of Injury: ______________

FAX TO: 503-814-5495

salemhealth.org/spine

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