Salem Health Spine Center

Referral Form

Salem Health® Hospitals & Clinics

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

Office Contact Person: _____ **Phone:** _____

Primary PCP: _____

Specific Neurosurgeon? ☐ Yes ☐ No

If yes: ☐ Collada ☐ Nanaszko ☐ Hatchette ☐ Kafka ☐ Gahramanov

Patient must have a spine level MRI with in the last 12 months

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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