

*Referrals can be made by faxing this form to our office.*

Date: \_\_\_\_\_

## FAX REFERRAL REQUEST

Number of Pages: \_\_\_\_\_

(Please do not send more than 30 pages)

### NEUROLOGICAL SURGERY

Ian T. Johnson, M.D.

#### REQUIRED PATIENT INFORMATION

Copy of Insurance Card (both sides) and Demographic Sheet

Insurance Authorization (Ex: TRICARE, HMO, etc.)

Worker's Compensation: Claim Number, Date of Injury, Adjuster/NCM Name and Contact Info)

Chart Notes

Has the patient been evaluated by a Neurologist or Neurosurgeon previously?  Yes  No

If yes: Please send reports

Has the patient had an MRI/CT or Xray in the last 6 months?  Yes  No

If yes: Please send reports

Has the patient been seen by pain management?  Yes  No

If yes: Please send last visit note

Has the patient been seen by Physical Therapy?  Yes  No

If yes: Please send first and last note only

Has the patient been seen by an Ophthalmologist?  Yes  No

If yes: Please send reports

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

PCP (If different from referring): \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Patient Cell: \_\_\_\_\_

Consultation For (Do not place ICD-10 codes\*): \_\_\_\_\_

Insurance: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Fax: \_\_\_\_\_

*Thank you very much for referring your patient to our office.*

[www.communityhealthpartners.org/community-neurosciences-institute-fresno](http://www.communityhealthpartners.org/community-neurosciences-institute-fresno)