Regional
Brain & Spine
Expertise. Service. Integrity.

Appointment/Consult Request Form

To request an appointment for your patient, please complete this form and return via fax to (573) 339-9709 along with:

•Office Notes •Medication List •Copy of Insurance Card •Imaging Reports •Previous pain clinic records, if applicable

Referring Provider Name:_____ Office Contact:_____

Phone:_____ Fax:_____ NPI:_____

Neurosurgery Provider Request: ____Dr. Vaught(NS) ____Dr. Tolentino(NS) ____Dr. Monaco(NS) ____1st Available

Pain Management Provider Request: ____Dr. Reis (PM) ____1st Available _____ Cape Clinic _____ Dexter Clinic

Reason for Appointment Request:_____

Patient Name:_____ DOB:_____ SSN:_____ Sex: M F

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Email:_____

Insurance:_____ ID#:_____

*Inform patient and/or referring office to contact their insurance carrier to verify we are IN-NETWORK. Certain plans have "carve outs" and it is the responsibility of the patient to know their insurance plan.

*If **UHC Medicare Advantage HMO plan** make sure we get **Referral** from **PCP**.

***Pain Management is the only provider who can see Wal-Mart Anthem BCBS.**

Is this referral due to a **work-related injury**? Y N

Is this referral due to a **motor vehicle accident**? Y N

Has the patient **had previous neurosurgeries** and/or **seen another neurosurgeon** and/or **been treated at a pain management clinic**? Y N

If yes, by which doctor and/or facility? _____

What previous studies, test, and/or treatments has the patient undergone?

___ MRI of _____ ___ CT Scan of _____

___ Xrays of _____ ___ Myelogram of _____

___ EMG/NCV of _____ ___ Bone Scan of _____

___ MRA or CTA of _____ _____ ___ Physical Therapy

___ Spinal Surgery ___ Muscle Relaxers ___ NSAIDs

___ Pain Medications ___ Steroid injections ___ Medrol dose pack

Other:_____