



Consultation Request Information Form

Charleston, WV
Fax Number (304) 343-0979

Requesting: **Emergency work-in or Next available**

Charleston Office

Teays Valley Office

Dr. Armbrust Dr. Crow Dr. Orphanos Dr. Schmidt Dr. Walker

▶ PATIENT INFORMATION

First Name: _____ M.I. _____ Last Name: _____ Male/Female

DOB: ____/____/____ SSN#: _____ - _____ - _____ Martial Status: **S M Other**

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

Home Phone: _____ Work Phone: _____

Cellular/Pager Phone: _____ Email Address: _____

▶ CONSULTATION INFORMATION

Requesting Physician's Name: _____ Date of Last Visit: _____

Physician Phone #: _____ Fax #: _____ Contact Person: _____

Reason for Consult: _____

▶ TESTING: (Please remind patient to bring radiology films or a CD containing films to their appointment.)

MRI - Date Completed: _____ CT Scan - Date Completed: _____

EMG/NCS - Date Completed: _____ X-ray - Date Completed: _____

Other Testing: _____ NONE

▶ Has patient had PREVIOUS NEUROSURGERY, SPINE, DISC OR BRAIN SURGERY?

(If yes): When? _____ By Whom? _____ (Please include prior surgery notes.)

Please note: Please feel free to Xerox this form for future referrals. Please fax this completed form along with the patients testing reports, physician notes and insurance cards to 304-343-0979 or 304-342-6927. Once all information has been received, we will notify the patient of the appointment and notify your office of the appointment date and time for your records. If you have not been notified within 24 to 48 hours of the appointment or you have any questions, please contact our appointments department at (304) 344-3551.

▶ INSURANCE INFORMATION

(Please, fax a copy of the patients insurance card(s).)

Insurance: _____ or Self pay: _____

Is the patient in a Managed Care Plan? ___ Yes ___ No Name of PCP on Card: _____

Authorization #: _____ Number of Visits: _____

▶ WV Workman's Compensation:

WC Claim ID #: _____ Case Manager: _____

DOI (COMP): _____ Authorization #: _____ (Please send copy)

MVA and Litigation Cases

Insurance Co./Attorney's Name: _____ Date of Accident(Auto/Other): _____

Thank you for your referral, we look forward to providing quality care to your patient.