

PLEASE FAX THIS FORM WITH THE FOLLOWING INFORMATION TO (207) 885-4402:

- Patient's Problem Requiring Evaluation (clearly stated either in notes or set forth below)
- Clinical Notes relating to the problem
- MRI report (if available) and any pertinent diagnostic study reports
- Medications List and Problems List (appreciated)  Copy of patient's Insurance Card (both sides)

PLEASE REQUEST THAT YOUR PATIENT BRING THE ACTUAL MRI OR RADIOGRAPHIC STUDIES TO THE APPOINTMENT

### Consult Request Information:

Date of Request: \_\_\_\_\_ Special Requests: \_\_\_\_\_

Problem Requiring Consult: \_\_\_\_\_

Onset of Problem:  <2 wks  <1-6 months  >6 months

	<b>R</b>	<b>L</b>		<b>R</b>	<b>L</b>		<b>R</b>	<b>L</b>
Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Leg Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Leg Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arm Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Arm Weakness	<input type="checkbox"/>	<input type="checkbox"/>

- RED FLAGS:** Progressive weakness/numbness in feet/legs  Numbness in groin/rectal area   
 Recent Trauma  Foot Drop  Fever   
 Significant weight loss  Night Sweats  Bowel & Bladder issues

Date/Place of Last Imaging: \_\_\_\_\_ (please attach REPORTS)

### Patient Information (or attach demographics)

Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Name: \_\_\_\_\_

City/State: \_\_\_\_\_ **Direct** Phone line: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Patient's PCP (if different): \_\_\_\_\_

D.O.B. \_\_\_\_\_ SSN#: \_\_\_\_\_ Language Spoken: \_\_\_\_\_

If patient is a minor, contact name: \_\_\_\_\_

### Patient Insurance Information – required

Insurance Carrier: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Authorization #: \_\_\_\_\_ # of visits: \_\_\_\_\_ Auth start date: \_\_\_\_\_ Auth end date: \_\_\_\_\_

Contact: \_\_\_\_\_

### Workers Comp Information – required if applicable

Date of workers comp injury: \_\_\_\_\_

WC Insurance Carrier: \_\_\_\_\_ WC Claim #: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone #: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_