Referral Form

Neurosurgery Associates

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Satellite Office: Memorial Hospital: 500 London Ave., Marysville, Ohio 43040 Phone: (937) 578-2020 Fax: (937) 578-2842

Thank you for choosing Neurosurgery Associates, LLC. Please complete this form to facilitate patient referral.

Referring Physician Information

Date: _____ Referring Physician Name: _____

Office Phone Number: _____Fax Number: _____ Faxed By: _____

Reason for Referral: _____

Circle Appointment Location: **Main Office-Columbus** Satellite Office-**Marysville**

Patient name: _____**Phone Number:** _____

Address: _____City: _____

State: _____ **Zip:** _____ **E-mail Address:** _____

Date of Birth: _____**Social Security Number:** _____

Primary Insurance: _____**Secondary Insurance:** _____

Imaging (MRI or CT of the brain or spine), must be completed within **6 months** of initial appointment.

If imaging is *not* completed at an OhioHealth facility the patient **must** bring a CD of their images, as well as the report(s) to the initial appointment.

If applicable, the patient must bring a copy of any EMG/NCS reports to their initial appointment.

We will schedule your patient once all the items below have been received please send:

A copy of the front and back of the patient's insurance card(s)

C-9 authorization and printed copy of allowable ICD-9 codes or insurance referral

The last office note, all imaging reports and a current medication list for the patient