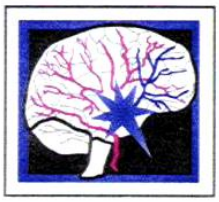

Please fax complete referral to:
916/771-3443

SPINE & NEUROSURGERY ASSOCIATES
A Medical Corporation

NEW PATIENT REFERRAL FORM

A complete referral includes:
New Patient Referral form
Office visit notes or a brief medical history
Current MRI report ***(within one year)***
Copy of insurance card or W/C information

Referred to:
- ☐ **Next available MD**
- ☐ **B. Barry Chehrazi, M.D., F.A.C.S.**
- ☐ **Kavian Shahi, M.D., Ph.D.**
- ☐ **Hamid Aliabadi, M.D.**

Referral Date: _____

Patient Name: _____

Address: _____

City / Zip: _____

Home Phone: _____

Alt. Phone: _____

DOB: _____

SSN: _____

Age: _____ M / F

Diagnosis: _____

Referring MD: _____

Address: _____

City / Zip: _____

Phone: _____

Fax: _____

NPI: _____

Patient PCP: _____

Phone: _____

Fax: _____

NPI: _____

**** *For all HMO & W/C patients:* Consultation must be approved prior to the referral being faxed ****

Primary Insurance: _____ ID: _____ HMO / PPO / PI

Secondary Insurance: _____ ID: _____ HMO / PPO / SUPP

Worker's Comp: _____ Claim: _____ DOI: _____
W/C adjuster: _____ Phone: _____ Fax: _____

Litigation: _____ Nature of injury: _____
Attorney Name: _____ Phone: _____ Fax: _____

FOR OFFICE USE ONLY

Date	Initials	Progress/Comments

Appt: _____ ☐ BBC ☐ KS ☐ HA ☐ RV ☐ CM
Via: ☐ phone ☐ in person ☐ MD office w/: _____
Films: ☐ patient to hand carry ☐ films in office
Packet: ☐ mailed ☐ faxed ☐ handed to patient on: _____
☐ to fill out in office / arrival time: _____