NEUROSURGERY AND SPINE NORTHWEST

WILLIAM F. GANZ MD FACS

REQUEST FOR CONSULTATION

PHYSICIAN REFERRAL SERVICE
PHONE: 208.664.5467 FAX: 208-765.4696

Referring Physician Information: **Date: _____**

Referring Physician Name: _____ NPI Number: _____

Clinic Name: _____ Contact Name: _____

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

Phone: _____ Fax: _____

Patient Information:

Patient Name as listed on Medical Records: _____

Date of Birth: _____ Social Security Number: _____

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

Phone Number: _____ Cell Number: _____

Patient Medical Insurance: _____

Policy Holder: _____ Date of Birth: _____ SSN#_____

Policy ID# _____ Policy Group # _____

Area of Concern: □ Brain Tumor □ DBS □ C-Spine □ L-Spine □ Carpal Tunnel

Has the patient had prior surgery for this issue? □ Yes □ No Physician _____

Surgical Procedure: _____ Date: _____

Reason for Referral: _____

_____

_____

Recent Diagnostic Testing:

□ MRI Date: _____ Facility: _____

□ CT Date: _____ Facility: _____

□ X-Ray Date: _____ Facility: _____

□ EMG Date: _____ Facility: _____

□ Bone Scan Date: _____ Facility: _____

Recent Treatment :

□ ESI's Date: _____ Facility: _____

□ Physical Therapy Date: _____ Facility: _____

□ Other: _____ Date: _____ Facility: _____