WEST VIRGINIA
# ORTHONEURO
Neuro/Spine Location

**3-STEP REFERRAL PROCESS:**
***1)*** *Complete this referral form*
***2)*** *Fax the form, radiology/testing reports, doctor's notes and insurance card to* ***(304) 343-0979***
***3)*** *We will notify the patient and your office with appointment date and time.*
***(or)***
*For urgent appointment needs, call our appointments department at* ***(304) 720-2284*** *or our main line at* ***(304) 344-3551***

Requesting: ☐ **Emergency work-in** or ☐ **Next available**
☐ **Charleston Office** ☐ **Teays Valley Office (Dr. Christiano only)**

☐ **Dr. Christiano** ☐ **Dr. Crow** ☐ **Dr. Harman** ☐ **Dr. Orphanos** ☐ **Dr. Schmidt** ☐ **Dr. Walker**
****All of our physicians perform spine surgery****

## ***PATIENT INFORMATION:*** **Email Address**: _____

First Name: _____ M.I. _____ Last Name: _____

**Male/Female** DOB: _____/_____/_____ SSN#: _____-_____-_____ Marital Status: **S M Other**

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

Home Phone:_____ Cell:_____ Other: _____

## REFERRING PROVIDER INFORMATION:

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

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

## PREVIOUS NEUROSURGERY, SPINE, DISC OR BRAIN SURGERY?

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

**PLEASE NOTE:** We need **ALL** previous **SURGERY** information/notes **BEFORE** scheduling.
To **AVOID** delays in scheduling, **DO NOT** send referral WITHOUT previous surgery notes.

## 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. Unless Marked URGENT, please allow 2-3 days for processing before contacting our office.**