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. 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 send ALL Imaging reports with referral – if not this could delay scheduling. Also - remind patient to bring a CD of images 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 (MUST send copy of AUTH): WC Claim ID #_____

AUTHORIZATION # _____DATE OF COMP INJURY: _____

Case Manager Name & Phone #: _____

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 3-4 days for processing before follow-up/calling. REFERRAL FAX # 304-343-0979