GOODMAN CAMPBELL
BRAIN AND SPINE

# Consultation Request

Patient name: _____ Date of birth: _____

Phone number: _____

**To expedite your referral, it is critical to provide the following information:**

**Reason for referral/ chief complaint:** _____

1. Patient demographic sheet
2. Copy of insurance card(s)
3. **Most recent** MRI/CT report
4. **Most recent** office visit note
5. Physical therapy notes (within the past 1 year)
6. Interventional pain management notes (if available)

☐ **Please check if the patient has not had any diagnostic testing.**

Is this a workers' compensation case?

☐ Yes ☐ No

Has the patient ever had spine surgery?

☐ Yes ☐ No

If Yes: Date: _____ Surgeon: _____

Has the patient consulted with another orthopedic/neurosurgeon regarding the same chief complaint?

☐ Yes ☐ No

If Yes: Date: _____ Surgeon: _____

Requested GCBS physician name: _____ OR

☐ First available neurosurgeon ☐ First available pain management physician ☐ First available interventional neuroradiologist

**Location preference**

☐ No preference / First available ☐ Carmel ☐ Ascension St. Vincent Fishers

☐ Avon ☐ Greenwood ☐ Ascension St. Vincent 86th Street (Pediatrics Only)

**Referral source information**

Referring doctor name: _____ Date: _____

Office contact: _____

Phone: _____ Fax: _____

Ability for office to send an electronic summary of care/CCDA ☐ Yes ☐ No

**PLEASE FAX THIS COMPLETED FORM AND ALL REQUESTED INFORMATION TO:**

Indianapolis: (317) 396-1443