# Carle Brain & Spine Referral Form

**PATIENT NAME**: ________________________________________________ DATE: ____________________

DATE OF BIRTH: ______________________________ SS#: _________________ CLINIC #: __________________

HOME ADDRESS: ________________________________________ TELEPHONE #: _________________________

TOWN: ____________________________________ STATE: ________________ ZIP: ____________________

**INSURANCE**: ________________________________________________________ WORK RELATED: Y N

If yes, employer: ________________________________ Contact: _________________ Phone: _____________

Work Comp Carrier: ______________________________ Contact: _________________ Phone: _____________

**REFERRAL SOURCE**: ______________________________ MD APP **PHONE**: _____________ FAX: ___________

**DIAGNOSIS**: ____________________________________ **Signs/Symptoms**: ______________________________

HT: _________ WT: _______ BMI: _________ Smoker: Y N Diabetic: Y N Hemoglobin A1C: __________

**PLEASE CHECK ONE OF THE FOLLOWING**:

______ This patient is being referred to a surgeon, patient has had an MRI/CT within the last 6 months. Report is enclosed. (Patient **must have** had an MRI/CT within the last 6 months to schedule with a surgeon). If referral for spine problem, and no previous treatment, patient will be scheduled with non-surgical spine specialist.

______ This patient has not had any of the treatments below and is being referred to a non-surgical spine specialist.

**PREVIOUS TREATMENT**:

**Injections / Procedures**: Type: _____________________ Date: ___________ Facility: ___________________

**Diagnostics**: MRI __________ Date: ________________ Facility: ___________________________________

CT ___________ Date: _________________ Facility: ___________________________________

X-rays ___________ Date: _________________ Facility: ___________________________________

EMG ____________ Date: _________________ Facility: ___________________________________

**Therapy**: Y N Facility Name: _________________________________________________________________

**Please complete above and send all records related to reason for referral.** Please include all radiology reports, MRI, CT, X-ray, etc. Please fax this information to: 217/326-0277. If you have questions, our office number is 217/383-6555. **Thank You for your referral**.

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Office use only: Schedule with: ___ Surgeon ________ APP ________ non-Surgeon

Does not meet surgical criteria due to: ____BMI > 40 ____no prev injections ____no prev therapy

____ no CT / MRI _____ no surgical finding on CT / MRI