REFERRAL FOR MID-MISSOURI NEUROSURGERY

PHONE: 573-815-8242

FAX: 573-815-8245

Referring Physician:____

Office Phone Number:_________________________Fax Number: ____________________________

Contact Person At Referring Physician's Office:____

Patient Name:____ Date of Birth:____________

Diagnosis:____

PLEASE SEND:

_____Demographics (DOB, address, phone number, etc)

_____Copy of insurance card (front/back)

_____Physician's notes (including physical exam findings/patient complaints/reason for surgical consult)

_____Radiology report detailing surgical issue (recent MRI or CT Myelogram). **Please inform the patient that they MUST bring a CD of the pertinent images to their appointment.**

_____Results of any conservative treatment (PT, ESI, etc)

_____Previous operative notes (if patient has had area operated on in the past)

_____Physician preference: CHARLES BONDURANT, M.D. or TERRENCE RYAN, M.D. or FIRST AVAILABLE

_____Has patient been seen at MMN previously? YES or NO

This information should be faxed to: ***573-815-8245*** *with this completed form. If the referring provider feels that this referral is of an URGENT or EMERGENT nature, please have their staff call the office to notify us of such.*

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Patient Appointment Date:____________________________Time:________________________

Physician:____

Mid-Missouri Neurosurgery will fax the referring physician's office with the appointment information, and will mail the patient an appointment packet to fill out and return to the office prior to their appointment.