Salina Regional Neurosurgery
Salina Regional Health Center

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Date: _____

Provider: _____ Fax: _____

Patient: _____ Date of Birth: _____

Appointment Date: _____

ALL IMAGING MUST BE WITHIN THE LAST 6 MONTHS OF APPOINTMENT.
PLEASE FILL OUT ALL INFORMATION AND FAX BACK WITH THE REPORTS.

1 MRI Report (Required) Facility Attended: _____
CT Report (Only accepted if patient has Pacemaker / Metal in Body / Spinal Cord Stimulator)
Lumbar / Thoracic / Cervical / Head (Circle One)

2 Physical Therapy Reports Facility Attended: _____

3 Anesthesia - Epidural Injection Reports Facility Attended: _____

4 Current Office Notes

5 Previous Surgery Operative Reports Doctor's Name: _____

6 EMG / Nerve Conduction Studies Facility Attended: _____

7 Current Medication List

8 Patient Demographic Sheet

9 Copies of ALL Insurance Cards -- Front and Back

10 A **written authorization is REQUIRED** for all Workman's Compensation and Auto Accidents
Claim Number: _____
Date of Injury: _____
Claim Adjuster Name: _____
Claim Adjuster Address: _____
Claim Adjuster Phone Number: ( ) ext: _____

N/A
(Circle if Not Applicable to WC or Auto)

11 An **authorization is REQUIRED** for all Tricare and Veterans Administration (VA) patients
Authorization/Reference Number: _____
Approval Date Range: _____
Number of Approved Visits: _____
Sponsor's Social Security Number: _____

N/A
(Circle if Not Applicable to Tricare or VA)

Thank you for the referral.

Salina Regional Neurosurgery
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