PIEDMONT SPINE & NEUROSURGICAL

CONSULTATION REQUEST
GREENVILLE OFFICE
PHONE #864-220-4263 FAX 864-269-0496 **

REQUESTED BY: DR. _____DATE:____/_____/_____

UP IN# _____NPI#_____ CALLER:_____
** These numbers are required before an appointment can be made. **

ADDRESS: _____CITY:_____ ZIP: _____

PHONE: (_____) _____- _____ FAX: (_____) _____- _____

PATIENT INFORMATION

FULL NAME: _____ DOB: _____/_____/_____
FIRST MIDDLE LAST

ADDRESS: _____
#STREET CITY STATE ZIP

HOME# (_____) _____-_____ WORK# (_____) _____-_____ CELL# (_____) _____-_____

SOCIAL SECURITY NUMBER: _____- _____-_____ EMAIL ADDRESS:_____
(Print please)

DIAGNOSIS: _____

SYMPTOMS: _____

ONSET OF SYMPTOMS: _____DATE OF INJURY:_____

IS THIS THE RESULT OF A WORK INJURY OR MOTOR VEHICLE ACCIDENT: YES / NO
(We do not file with motor vehicle insurance.)

TYPE OF DIAGNOSTIC PROCEDURES:_____LOCATION:_____

TREATMENT: (Example: physical therapy, pain management.) Please list: _____

HAS THE PATIENT HAD SURGERY FOR THIS CONDITION BEFORE? YES / NO; WHEN? _____

BY WHOM? _____ LOCATION: _____

INSURANCE COMPANY: _____ POLICY#: _____

PLEASE SPECIFY: DR. BUCCI / DR. MINA / FIRST AVAILABLE

PLEASE FAX THE FOLLOWING TO (864) 269-0496 ** (Only fax what is pertinent to appt. request.)

- COPY OF INSURANCE CARDS, FRONT AND BACK. (PLEASE OBTAIN REFERRAL AUTHORIZATION IF NEEDED
- TREATMENT NOTES
- DIAGNOSTIC REPORTS
- **PLEASE HAVE PATIENT BRING FILMS / DISK TO APPT. THE PATIENT CANNOT BE SEEN WITHOUT IT.**

WE WILL CONTACT THE PATIENT WITH THE APPOINTMENT TIME ONCE THE ABOVE INFORMATION HAS BEEN RECEIVED AND REVIEWED. PLEASE NOTE THAT SOME REFERRALS REQUIRE THE DOCTORS' REVIEW OR PRIOR AUTHORIZATION AND MAY TAKE LONGER TO SCHEDULE. PLEASE ALLOW 5 TO 7 DAYS DUE TO HIGH VOLUME OF REFERRALS.