CoxHealth
Jared Neuroscience Center

REQUEST FOR CONSULTATION

Phone: 417.631.0175 or 1.866.490.7119 Fax: 417.881.7618

WITHOUT THE FOLLOWING INFORMATION, WE ARE UNABLE TO MOVE FORWARD WITH SCHEDULING

____ Insured ____ Self-Pay ____ Workers Comp (see reverse)

Reason for Consultation: _____

Prior Related Surgery: ❑ NO ❑ YES (If YES, please include operative report, if available)

Patient Name: _____ DOB: _____

Patient Address: _____

Best Phone: _____ Alternate Phone: _____ Best time to call: _____

Referring Physician: _____ Office Phone: _____

Office Fax: _____ Contact Name: _____

❑ Patient Profile Sheet ❑ Most Recent Office Note ❑ Diagnostic/Imaging Reports

❑ Copy of Insurance Card, Front/Back - Type: _____

ID Number: _____ Group Number: _____

❑ Hearing Impaired Interpreter Needed ❑ Foreign Language Interpreter Needed - Please Specify _____

PHYSICIAN REQUESTED

❑ **1st Available - Neurosurgery**
❑ H. Mark Crabtree, MD, FACS
❑ Edwin J. Cunningham, MD
❑ J. Charles Mace, MD, FACS
❑ Chad J. Morgan, MD
❑ Mayur Jayarao, MD
❑ Michael Mumert, MD
❑ Salim Rahman, MD, FACS
❑ Angela Spurgeon, DO
❑ Robert D. Strang, MD

Neurointerventionalist
❑ Michael J. Workman, MD

FACILITY

❑ **Springfield, MO (All Physicians)**
❑ Branson, MO (Dr. Mace)
❑ Carthage, MO (Dr. Morgan)
❑ Harrison, AR (Dr. Spurgeon)
❑ Monett, MO (Dr. Mumert)
❑ Mountain Home, AR (Dr. Crabtree)
❑ Rolla, MO (Dr. Cunningham)

PAST FILMS *(PLEASE ATTACH REPORT)*

FACILITY/DATE

❑ EMG/NCV _____
❑ MRI _____
❑ CT _____
❑ Myelogram _____
❑ Related X-Ray _____
❑ Other _____ _____
❑ No Films _____

FOR OFFICE USE ONLY

Patient Notified: _____ Date Referring Physician Notified: _____

Appointment Date / Time: _____ Physician: _____ Location: _____

Today's Date / Time: _____ Initials: _____

CoxHealth
Springfield, MO
Springfield Neurological and Spine Institute

REQUEST FOR CONSULTATION PHYSIATRY

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Reason for Consultation _____

Patient Name: _____ Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ DOB: _____ SSN: _____

For Workers Compensation only:

Name of employer: _____

Workers Compensation Company Name: _____

Address: _____

City: _____ *State:* _____ *Zip:* _____

Adjuster/Nurse Case Manager: _____ *Phone:* _____

Workers Compensation Claim Number: _____ *Date of Injury:* _____

Is this a Missouri Workers Compensation claim? ❑ *Yes* ❑ *No* *If NO, what state?* _____

Physical Medicine and Rehabilitation

❑ **1st Available**

❑ Ted A Lennard, MD

❑ Jeffrey L. Woodward, MD

PAST FILMS *(PLEASE ATTACH REPORT)*	**FACILITY/DATE**
❑ EMG/NCV	_____
❑ MRI	_____
❑ CT	_____
❑ Myelogram	_____
❑ Related X-Ray	_____
❑ Other _____	_____
❑ No Films	_____

FOR OFFICE USE ONLY

Patient Notified: _____ Date Referring Physician Notified: _____

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Today's Date / Time: _____ Initials: _____