



**The
Ortho-Spine
Rehabilitation
Center, Inc.**
7211 Sawmill Rd., Suite 101, Dublin, OH 43016

Referral Fax Cover Sheet

Fax: (614)793-8837

Phone: (614) 793-8817

Total Pages Sent _____

Patient Demographic Information

Patient Name:	Phone:
Date of Birth:	Insurance Type:
Address:	City, State, Zip:

Referring Physician Information

Physician Name:	Phone:
Contact Person:	Fax:
Address:	City, State, Zip:

Consultation Information

Diagnosis Codes:
Appointment Date/Time (if previously scheduled):

Please check the reason for referral below. (Only check one)

<input type="checkbox"/>	Consultation Only / 2nd Opinion
<input type="checkbox"/>	Evaluation and Treatment
<input type="checkbox"/>	Other (please specify):

Please fax or mail this form along with the following information to our office:

1. Pertinent medical records. (If extensive, please send the last three office notes with history pertinent to the referral to our office.)
2. Pertinent diagnostic studies/reports. (MRI, CT, X-Ray, EMG, Bone Scan, Lab, etc.)
3. Prescription medication history including list of current medications.
4. Surgical history and operative/procedural notes.
5. Copy of insurance card and demographics

You may call our office to schedule the appointment prior to forwarding this information to our office, or send the information, and we will be happy to contact the patient to schedule the appointment with them.

Thank You for the Referral!