New Patient Referral Form

1010 E. Third Street, Suite 202 ● Chattanooga, TN 37403
P: (423) 265-2233|**F:** (423) 321-1112 or **F**: (423) 756-8265
www.chattanooganeurosurg.org

Date: _____

(Please Circle) MD / DO / D

Referring Doctor: _____

_____

Address:_____

Contact Name:_____F

Select a Doctor to see patient:

□ Peter Boehm, Sr., MD □ Michael Gallagher, MD □ Peter Boehm, Jr., MD
□ Timothy Strait, MD □ R. Lee Kern, Jr., MD □ Paul Hoffmann, MD
□ D. Philip Megison, MD □ Daniel Kueter, MD

Patient Name First:_____ M.I._____ Last:_____

_____

DOB:_____ SS#:_____

Address:_____

Home Phone:_____ Cell Phone:_____

DX:_____ **Insurance/ID#:**_____

1. Has patient had previous brain or spine surgery? □ Yes □ No
2. Does patient reside in a nursing home facility? □ Yes □ No
3. Is patient currently in pain management? □ Yes □ No
4. Is this: □ **Auto Accident** □ **Workers Comp** □ **Accident**

Please fax all relevant med. records, including: Labs, MRI, X-Ray, EMG, NCS, & Office Notes
Also Insurance Cards

Patient will need to bring CD or actual films of imaging studies for direct review by our physicians.

Please contact your patient with the appointment date & time

Appointment Date/Time: _____

_____

For office use only

CNS CHART #_____

_____ Revised 10-1-2013