TEXAS CENTER FOR NEUROSCIENCES

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PATIENT REFERRAL FORM

*****For all Brain or Spine Problems, Please Bring Actual Imaging Films which Must Include MRI or CT scans (Films may be on CD ROMS) *****

Also, please bring office notes, reports, medication list, insurance cards.

Patient Name: _____

Referred By:_____

Phone Number:_____ Fax:_____

Demographics (Age, Sex, Date of Birth):	Primary Insurance Info:
Patient Contact Info:(Address, Phone #)	Secondary Insurance Info:

Brain Pathology Diagnosis/Reason for Referral:	**Spine/PN Pathology** Diagnosis/Reason for Referral:
Imaging/Studies Performed: □CT of Brain □CTA/CTV □MRI Brain □MRA/MRV □ Cerebral Angiogram □ Other:_____	Imaging/Studies Performed: X-rays: □ C-spine □ T-spine □ Lumbar CT: □ C-spine □ T-spine □ Lumbar MRI: □ C-spine □ T-spine □ Lumbar Myelogram: □ C-spine □ T-spine □ Lumbar □ EMG/Nerve Conduction □ SSEP/MEPs □ Other_____

Please FAX form to 1-855-790-3974

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