Request for Surgical Consultation to:

NEUROSURGICAL ASSOCIATES, LTD.

Brain & Spine Specialists SM

Phone: 612-871-7278
Please fax completed form to: 612-863-8531

Today's Date:____

Patient Name:____

DOB:______________________________ MRN#:____

Please fax demographic and insurance information – OR - fill out the following information:

Home Address:__________________________________City, State, Zip:______________________

Home Phone: ______________________________Work/Other Phone:_________________________

Insurance: ____

Referring Provider Name:____

Contact Phone #: ____________________________Contact Fax #:_____________________________

Reason for Surgical Consultation (Specific Surgical Diagnosis):______________________________

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- □ Mahmoud Nagib, M.D.
- □ Thomas Bergman, M.D.
- □ John Mullan, M.D.
- □ First Available
- □ Walter Galicich, M.D.
- □ Michael McCue, M.D., Sc.D.
- □ Ciro Vasquez, M.D.

Note: It is our request that patients have a recent diagnostic test such as a MRI, CT, Myelogram, EMG, etc. done within the past 3-6 months to confirm a surgical diagnosis. Along with these test results, please fax all patient chart notes that may be relevant to this consultation request. Thank you.

We will contact the patient directly unless you advise us otherwise.

If the referring physician requests to be notified of the appointment date/time, please let us know.

NSA USE ONLY:

Appointment Date:________________________________Time:______________________________

Physician:____Location:____Minneapolis______________

Patient Notified? Yes No Initials:____________________Faxed:___________________________

Thank you for your referral!
www.neurosurgicalassocs.com