

**NEUROSURGICAL/  
INTERVENTIONAL PAIN MANAGEMENT  
CONSULTATION REQUEST**

**Phone: (317) 396-1199**

Date: \_\_\_\_\_

**Referral Source Information:**

Referring Doctor: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Requested ING Doctor:** (Please Circle Preferred Physician or First available)

\_\_\_\_\_ *Neurosurgical Consultation*

*Dr. Michael Burt*

*Dr. Peter Gianaris*

*Dr. Thomas Leipzig*

*Dr. Michael Turner*

*Dr. James Callahan*

*Dr. David Hall*

*Dr. Jean-Pierre Mobasser*

*Dr. Ronald Young*

*Dr. Aaron Cohen-Gadol*

*Dr. Terry Horner*

*Dr. Troy Payner*

**First Available**

*Dr. Jeffrey Crecelius*

*Dr. Steven James*

*Dr. Eric Potts*

*Dr. Randy Gehring*

*Dr. Saad Khairi*

*Dr. Carl Sartorius*

\_\_\_\_\_ *Pain Management Consultation*

*Dr. Jose Vitto*

*Dr. Derron Wilson*

**First Available**

**Patient Information:**

Legal Name: \_\_\_\_\_ M.I. \_\_\_\_\_ D.O.B. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone:( ) \_\_\_\_\_ - \_\_\_\_\_

**Diagnosis/Symptoms:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Prior Testing / Surgery (Type, When, Where):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information:**

Company Name : \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Type / Name: \_\_\_\_\_

Policy #: \_\_\_\_\_

Precertification Required: Yes / No

**Please fax with this sheet the following information:**

- Patient Demographic Information
- Radiology Reports
- Doctors Office Notes
- Procedure Notes
- Insurance Card Copy
- Labs (if applicable)

**Please fax to: (317) 396-1443**