



Bell Neuroscience Institute of Silicon Valley

Part of Washington Township Medical Foundation

Neurosurgery / Neurointerventional Surgery

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Date/Time Sent: _____

Pages (including cover): _____

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REFERRAL FAX FORM

Thank you for choosing Washington Township Medical Foundation Neurosurgery department for your patient's healthcare needs. We look forward to collaborating with you on your patient's treatment plan.

To start the referral process, please fax this completed form to the Neurosurgery Department. If you require additional assistance, please call our office and ask for Alicia Osborn, New Patient Coordinator for the Neurosurgery Department.

PATIENT INFORMATION (or attach a face sheet that includes this information)

Name of Patient: _____
DOB: _____ Interpreter Needed: YES NO Language: _____
Home phone: _____ Work phone: _____ Cell phone: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Plan Name: _____ ID #: _____

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-10: _____
Reason for referral: _____

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ Specialty: _____
Phone: _____ Fax: _____
Office Contact Person: _____ Phone: _____

REQUIRED DOCUMENTATION (fax with this form)

- Brief pertinent Medical Records, including test results that support the consultation
- Patient's insurance card (both sides) and HMO authorization, if required
- Any Imaging reports and/or past procedural notes if applicable.

NOTE: Any radiological images not performed at Washington Hospital may be needed prior to the first consultation.

WARNING: THIS FAX TRANSMISSION MAY CONTAIN CONFIDENTIAL MEDICAL INFORMATION

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CONFIDENTIAL AND PRIVILEGED.

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