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): _____

Eldan Eichbaum, MD, FACS ☐
Desmond Erasmus, MD ☐
Sandeep Kunwar, MD, FACS ☐
Jeffrey Thomas, MD, FAANS, FACS ☐

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.
