Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 650-3565
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Spine Surgery

Diagnosis: _____

(Please include operative/procedure notes and any pertinent imaging and reports with the referral (please limit to 30 pages)

Clinical Question You Want Answered or Description of Patient Symptoms: _____

_____

Pertinent Image Studies: ❑ MRI ❑ CAT Scan ❑ XRAY ❑ Other (please specify): . _____

_____

Images Studies (images and reports) included in referral? ❑ No ❑ Yes If No, please specify where and when studies were completed: _____

MRI is required for Spine complaints. If an MRI is medically contraindicated, a CT is a reasonable alternative. If no advanced imaging can be obtained, we can offer a remote Telemedicine screening clinic visit with a Spine Advanced Practice provider to get the patient started with our clinic.

Are you requesting a specific provider? If so please list here: _____

Referring Provider's Signature _____ Date_____