OREGON NEUROSURGERY

Referral
FAX TO: 541-681-3088
Office Phone: 541-686-8353

Oregon Neurosurgery
3355 RiverBend Drive, Suite 400
Springfield, OR 97477

Date

Referred by Dr. | Office Number

Your Name | Fax Number

❑ SAME
Patient's PCP | Other

Patient is being referred to Doctor(s): ***(Please check one)***
❑ First available ❑ Bilbao ❑ Hutton ❑ Kokkino ❑ Kosek ❑ Roundy

Patient Name. | Date of birth

Telephone numbers: Home | Daytime

Address City/State Zip | Social Security

Diagnosis

Symptoms

- Imaging (MRI or CT Myelogram) must be done within last year

Location of films/studies: ❑ ImageCast ❑ OMG ❑ MWH ❑ WVI ❑ MR Imaging

Other:

Insurance Company | ID #

Group # | ❑ Commercial ❑ OHP ❑ Worker's Comp ❑ Motor Vehicle Accident

PLEASE FAX A COPY OF INSURANCE CARD WITH THIS FORM
Please include any relevant CHART NOTES & MRI REPORTS
Once we have received all reports we will contact the patient with an appointment date and time. Thank you

Place patient label here