The Spine Institute

Carmel Medical Pavilion, 13431 Old Meridian St., Ste 200, Carmel, In 46032
Phone (317) 573-7733 Fax (317) 573-7739

James W. Hardacker, M.D. *Amanda J. Hobson, PA-C*

Patient Referral Form

Referring Dr.: _____ **Contact Name**: _____

Office Phone: _____ Office Fax: _____

Patient Name: _____

Patient Contact Number: _____

Email Address: _____

Insurance Carrier: _____ **ID#**: _____

Please fax a copy of the patients demographics page including a copy of the insurance card.

Reason for Referral: _____

_____

Work Comp? ____Yes ____No **Motor Vehicle Accident**? ____Yes ____No

Date of Occurrence: _____ **Name of carrier**: _____

Please fax the claim number, Case Manager and the adjuster's information.

Previous Spine Surgery? ____Yes ____No **Date of Surgery**: _____

Previous Surgeon: _____

Please fax a copy of the operative note(s)

MRI? ___Yes ___No, if No what date is it scheduled for _____

CT? ___Yes ___No **X-Ray**? ___Yes ___No

Please make sure that you inform your patient that they have to bring all films related to the spine with them to their appointment. Please fax the reports.

Thank you,
The Spine Institute Staff