BIANCO BRAIN AND SPINE LLC

1001 Waldrop Drive Ste 403 Arlington, TX 76012
Ph: (817) 701-4253 Fax: (817) 701-4258

Referral for Neurosurgical Consultation

*these forms are optional, most like to just call us!

If a patient needs an appointment as soon as possible please call our office directly. Please complete this form and fax it, along with copies of insurance cards, and most recent medical records to the above number. Our office will contact the patient with an appointment as soon as all information has been received. We will then notify your office of the appointment date and time for your records.

First Name:____________________ M.I. ________ Last Name:____________________ Sex: ☐ F ☐ M

DOB: ______/______/______ SSN: ______-______-______ Marital Status: ☐ S ☐ M other:____________

Address:______________________________ City: ______________ State: ______ Zip: __________

Home Ph: (_____)____________ Work Ph: (_____)____________ Cell Ph:(_____)____________

Employer: ______________________

INSURANCE INFORMATION: [Please fax a copy of the front & back of the insurance card(s)]

Insurance: ______________________________ Name of PCP:______________________________

Authorization #:______________________________ Number of Visits: __________ Is Patient Self Pay? ______

MVA & Litigation Cases: Insurance Co./Attorney's Name______________________Date of Accident:__________

CONSULTATION INFORMATION:

Referring Physician:______________________Ph: (_____)____________Fax: (_____)____________

Contact Person:______________________

Reason for Consultation: ☐ Neck ☐ Back ☐ Brain

☐ Pain ☐ Tumor ☐ Hydrocephalus
☐ Fracture ☐ Anuerysm ☐ Disc Degeneration
☐ Other______________________________

Testing: ☐ MRI – Date/Facility:______________________________
☐ CT Scan – Date/Facility:______________________________
☐ Xray – Date/Facility:______________________________
☐ EMG/NCS – Date/Facility:______________________________
☐ Angiogram – Date/Facility:______________________________
☐ Discogram – Date/Facility:______________________________
☐ NONE

Any Neurosurgical History?

Type of Surgery:______________________________ When:____________________

By Whom:______________________________