BUCKEYE SPINE & REHAB – REFERRAL FORM
Phone: 740-681-1582 Fax: 740-681-1586

(circle one)

Appt Date/Time ____________________

Dr. Bell **(Also available in Canal Winchester, Diley Ridge Medical Facility – Tuesday mornings)**
Dr. Higgins
Dr. Meszaros
First Available

Please complete entire form and fax to our office along with the information requested below. Once we have received the necessary information as specified below, we will contact your patient with an appointment. We will fax this form back to you with their appointment confirmation.

Patient Name: ______________________________ DOB: _______________ **SS#** ____________________________

Address____

Phone # ____________________________________ **Cell Phone #** ____

Insurance: ______________________________ PREAUTH Y N

Name of insurance carrier if other than patient: _________________________ DOB ____________________________

Ref Dr.. _________________________ P# ______________ F# ____

Address: ____

NPI # __________________________REF DRS. M/CAID#____

Has patient every been treated by any physician in our practice? ______ If so, approximate date ______________

REASON FOR REFERALL? ____

- -

EMG: LUE LLE RUE RLE BUE BLE
REASON FOR TEST? ____

IS THIS A WORK RELATED INJUURY? ***Y N***

****IF BWC INJURY, PLEASE OBTAIN THE FOLLOWING INFORMATION:***

BWC # __________________________ MCO ____

DATE OF INJURY? ______________APPROVED C9? _____**(must have to schedule)**

ALLOWED CODES ____

IS THIS THE RESULT OF A MOTOR VEHICLE ACCIDENT? Y N
If yes, please call the office at 740-681-1582.

- **We must receive the following information prior to scheduling**
  - **Referral authorization / BWC approved C9**
  - **Copy of insurance card (front & back)**
  - **Office notes pertaining to the reason patient is being referredCurrent MRI's, CT Scans, Xrays – Films and reports and recent lab reports**