

REFERRAL DOCUMENT CHECKLIST

Include these with your referral fax because we will be able to see your patient sooner - thank you.

- Photo ID** - Copy of patient's photo ID card you have on file (i.e. driver's license)
- Insurance cards** (primary and secondary insurance, front and back of card)
- Insurance authorization** (if required by HMO network for specialist surgeon referral)
- Chart summary** (current diagnoses, medical and surgical history, meds, allergies)
- Clinic notes** and specialist consult notes relevant to this referral
- OP reports**, reports of any recent procedures (diagnostics, interventional, pain injections)
- Imaging reports** (CT and MRI reports related to this referral)

REASON FOR CONSULTATION

Diagnosis _____

ICD-10 codes _____

Brief narrative _____

PATIENT INFO

Full name _____

Email _____ Date of birth _____

Cell phone # _____ Other phone # _____

Street address _____

City/State/Zip _____

INSURANCE

PRIMARY

SECONDARY

Name _____

Group ID _____

Policy # _____

REFERRING PHYSICIAN

Referring MD _____

Specialty _____

Phone _____ Fax _____

Primary care provider (if different from referring MD) _____

By providing the requested information and signing below, you agree that we may initiate treatment or perform further diagnostics as medically indicated. We look forward to collaborating with you on your patient's treatment plan.

Thank you for choosing to refer your patient to Cerbo Clinic Neurosurgery.

Referring Physician Signature

Date

Send the completed form and referral documents to FAX 650.257.2979
Any questions? Call us at 650.257.2976 or email support@cerboclinic.com

NOTICE OF CONFIDENTIALITY: If you are not the intended recipient, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.