TNC BRAIN & SPINE
NEUROSURGERY | NEUROLOGY | PAIN MANAGEMENT

1401 Centerville Road
Suite 300
Tallahassee, FL 32308

New Patient Referral Form

INSTRUCTIONS

Please indicate which department and physician (if you have a preference) you are referring your patient to. **Note that our office requires medical records and any studies performed such as, MRI, EMG, X-Ray, etc. should be sent along with this referral**.

SELECT DEPARTMENT	SELECT PHYSICIAN					FAX REFERRAL TO
☐ Neurology	☐ Dr. Martin	☐ Dr. Ayala	☐ Dr. Ortiz	☐ Dr. Estupinan	☐ Dr. Martinez	**850-942-6515**
☐ Neurosurgery	☐ Dr. Albert Lee	☐ Dr. Lawson	☐ Dr. Beaty	☐ Dr. Davis		**850-656-3645**
☐ Stroke Neurology	☐ Dr. Mena Samaan					**850-656-3645**
☐ Pain Management	☐ Dr. Fuhrmeister	☐ Dr. Lynch				**850-558-1298**

Appointment Requested: ☐ **New Patient Consultation** ☐ **EMG Study**
LT/ RT/ BIL **Arm / Leg**

Is visit related to an auto accident? __ NO __YES
Is visit related to a worker's comp injury? __ NO __YES
Has patient had an MRI and/or X-rays? __NO __YES If yes, please send report with referral

PATIENT INFORMATION

Patient Name	__ Male	__ Female
DOB	SSN	
Parent/Guardian (if minor)		
Address Email address		
Phone (Home/Work/Cell) *circle one*	Alternate Phone (Home/Work/Cell) *circle one*	
Primary Insurance Name		ID#
Secondary Insurance Name		ID#

REFERRING PHYSICIAN

Name of Referring Doctor:	
Phone	Fax
Primary Care Physician (*required*)	
Phone	Fax
Please indicate diagnosis/reason for visit:	

SIGNATURE OF REFERRING PHYSICIAN IS REQUIRED FOR AN APPOINTMENT TO BE MADE. PLEASE FAX ALL PERTINENT RECORDS WITH THIS REFERRAL. PLEASE NOTIFY THE PATIENT OF THIS APPOINTMENT.

Sign:

APPOINTMENT SCHEDULED

Appointment with Dr:

Date **Time** **am / pm**