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**. Documents will be reviewed by a physician at the time of the patient appointment. Tallahassee Neurological Clinic does not accept responsibility or liability for the content of such medical records until a physician-patient relationship is established during the patient's appointment visit. In the event a referring physician considers immediate review of forwarded medical records by a TNC physician to be necessary, direct physician to physician contact is required.

SELECT DEPARTMENT	SELECT PHYSICIAN					FAX REFERRAL TO
☐ Neurology	☐ Dr. Martin	☐ Dr. Ortiz	☐ Dr. Estupinan	☐ Dr. Martinez	☐ Dr. Bohanan	**850-942-6515**
☐ Neurosurgery	☐ Dr. Albert Lee	☐ Dr. Lawson	☐ Dr. Beaty	☐ Dr. Davis	☐ Dr. Baum	**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**