GEORGIA SPINE & NEUROSURGERY CENTER

Minimally Invasive Maximum Results

Physician Referral Form

Please fax this form and additional information to (404)299-3315.
If you have any questions, please call (404)299-3338.

REFERRING PHYSICIAN INFORMATION

Date: _____

Physician Name: _____ Office Name: _____

Phone: (_____)_____ Fax: (_____)_____

REQUESTED APPOINTMENT

Preferred Provider: ☐ Kaveh Khajavi, MD ☐ Richard Gullick, MD ☐ Anthony Hutchison, ACNP

☐ No preference **(Note: not all providers go to all locations.)**

Preferred Location: ☐ Decatur ☐ Midtown ☐ Stockbridge ☐ Newnan ☐ First available

Appointment Urgency: ☐ STAT ☐ Expedited (1-2 wks.) ☐ Routine (3-4 wks.) ☐ 2nd Opinion

PATIENT INFORMATION

Name: _____ DOB: _____

Primary Care Physician: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Insurance: _____ Member ID: _____

Diagnosis/Reason for Referral: _____

_____

_____

_____

ADDITIONAL INFORMATION

Please include the following with this referral form. Items in bold are required.

☐ **Insurance card** ☐ **Imaging study reports** ☐ Demographics

☐ Office notes ☐ Procedure notes ☐ Recent lab work

Thank you for allowing us to participate in the care of your patient.

Georgia Spine & Neurosurgery Center
P: 404-299-3338 F: 404-299-3315
www.gaspine.com