GEORGIA
BRAIN & SPINE
CENTER

REFERRAL FORM

Phone: 800.GO.SPINE • 404.446.4424 • **Fax:** 404.446.4420
email: referral@georgiabrainandspine.com
www.georgiabrainandspine.com

Date: _____

Preferred Provider:

_____Elias Dagnew, MD _____Michael Hartman, MD _____First Available

Patient Name: _____

Date of Birth: _____

Patient Phone: _____

Patient Insurance: _____

Referring Doctor: _____

Referring Doctor Phone: _____ **Fax:** _____

Reason for Referral (Evaluate and Treat):

_____Neck _____Back _____Brain _____Peripheral Nerve _____Other

Reason for Referral (Treatment): _____ESI _____Facet Injection/RFA Therapy

_____SCS Evaluation _____Kyphoplasty/Vertebroplast

Previous Treatments: _____Chiropractic _____Physical Therapy _____Neurology

_____Pain Management

Clinical History/Special Instructions: _____

_____

Please Fax or Email:

1. Applicable Medical Records
2. MRI/CT/X-ray Reports
3. Patient Insurance Card and Demographics
4. Copy of this referral form

Thank You for the Referral