

NEUROSURGICAL SPECIALTIES

University of Florida

NEW PATIENT REFERRAL FORM

Phone: (352) 273-6990

Fax (352) 392-2443

*****PLEASE FAX DIAGNOSTIC STUDIES
& MOST RECENT NOTES ONLY*****

Physician Information:

Please Indicate Physician Requested:

Foote • Friedman • Hoh • Jacob • Lewis • Pincus (pediatric) • Roper • On Call

Patient Information:

Patient's name: _____ DOB _____ M or F

Parent's Name: _____ Relationship _____

Address: _____ SSN _____

City: _____ State: _____ Zip: _____

Home # (____) _____ Work # (____) _____ Race ____ Marital Status _____

Diagnosis:

Reason for Referral:

Referring Physician Information:

Name: _____ Contact: _____

Address: _____ City: _____ St: ____ Zip: _____

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

Specialty: _____ UPIN: _____

PCP Information (if different from referring MD):

Name: _____ UPIN: _____

Address: _____ City: _____ St: ____ Zip: _____

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

Guarantor/Insurance Information: Please Provide Authorization & Copy of Card

AvMed BC/BS Medicare Medicaid Medicaid/Medipass Provider # Required _____

Other: _____

Claim Address: _____ City: _____ St: ____ Zip: _____

Policy No: _____ Group No: _____ Phone: _____

Policy Holder: _____ Relationship to pt: _____ Policy Holder DOB: _____

Policy Holder SSN: _____

AUTHORIZATION NUMBER: _____ No Visits Auth: _____ Expires: _____