

REQUEST FOR CONSULTATION  
Department of Neurosurgery, University of Florida

**Fax to 352.392.2443**

Phone 352.273.6990

Attach most recent test results (<than 6 months) and notes

Please attach copy of insurance card

Circle one

FOOTE    DUNBAR    FRIEDMAN    HOH    JACOB    LEWIS    MURAD    MOCCO    PINCUS    ROPER

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ M/F \_\_\_\_\_

Address: \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell \_\_\_\_\_

\_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Referring physician name: \_\_\_\_\_ Contact \_\_\_\_\_

Address: \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI \_\_\_\_\_

PCP name: \_\_\_\_\_ Contact: \_\_\_\_\_

(if different from referring)

Address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI \_\_\_\_\_

First insurance name \_\_\_\_\_ Phone: \_\_\_\_\_

Claim address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Policy holder name \_\_\_\_\_ Policy number \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_ Authorization # \_\_\_\_\_

Second insurance name \_\_\_\_\_ Phone: \_\_\_\_\_

Claim address \_\_\_\_\_ City, State \_\_\_\_\_ Zip \_\_\_\_\_

Policy holder name \_\_\_\_\_ Policy number \_\_\_\_\_ Group # \_\_\_\_\_

Relation to patient \_\_\_\_\_ Authorization # \_\_\_\_\_