

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

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

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

SSN \_\_\_\_\_ 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 # \_\_\_\_\_