



EAST TENNESSEE BRAIN & SPINE CENTER

New Patient Referral Form

Fax To: (423) 232-8304

Physician Requested

Neurosurgery

- Dr. David Wiles
- Dr. Timothy Fullagar
- First Available

Pain Management

- Dr. Marc Valley
- Dr. Ihab Labatia
- First Available

Today's Date: _____

Patient Name: _____

DOB: _____ SSN: _____

Address: _____

Home Phone #: _____

Work #: _____ Cell #: _____

Patient's Insurance: _____

Referring Physician: _____

Phone: _____ Fax: _____

Physician NPI#: _____

Has this patient been seen by another:

1. Neurosurgeon? Y N If yes, Doctor: _____ Date(s): _____

2. Pain management clinic? Y N If yes, Doctor: _____ Date(s): _____

Reason for Referral

- Neck Pain
- Back Pain
- Abdominal Pain
- Headaches
- Cancer Pain
- Other: _____

Priority

- Urgent*
 - Routine
- *If Urgent, please provide more detail: _____
- _____
- _____
- _____

*Pertinent medical records and a copy of the patient's insurance cards (front and back) **must accompany this referral** for an appointment to be set up. Please allow up to 48 hours processing time once all the information is received. If the patient requires a referral, please fax it to us at least 3 business days prior to the appointment date.

The information below will be faxed back to the number given above.

Appointment Date: _____ Time: _____

Physician: _____

**It will be your responsibility to contact the patient and advise them of this appointment.