group health Cooperative of eau claire

Request Form

Surgical Consult for Low Back Pain

Patient's Name: _____ DOB: _____ ID#: _____

Referring Provider: _____ Tax ID: _____ Fax#: _____
Name/Clinic

Refer to Provider: _____ NPI: _____
Name of Orthopedic Spine Surgeon/Neurosurgeon/Clinic

Phone #: _____ Tax ID: _____ Fax#: _____

Diagnosis: _____ ICD-9: _____

Please indicate if any of the following are present:

- ☐ Fever
- ☐ Pain for More Than 6 Weeks
- ☐ Osteoporosis
- ☐ Immunosuppression
- ☐ Neurodeficit
- ☐ Unexplained Weight Loss
- ☐ Trauma
- ☐ Prior Spine Surgery
- ☐ H/O Cancer
- ☐ IV Drug Use

Please indicate the reason for requesting this consult or referral: _____

_____

_____

Patient has failed the following treatments:

☐ NSAIDs ☐ Spinal Injections ☐ Physical Therapy ☐ Chiropractic Treatment

Please send clinical information to assist in the decision for the need of this referral.

Projected Appointment Date: _____

_____ _____ _____ _____
Provider Contact Name | Phone # | Fax # | Date

Please refer to the Provider Manual for specific information regarding our network referrals.

Privacy and Confidentiality:
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