The Ohio State University Medical Center
Department of Neurological Surgery
410 W. 10th Avenue
Columbus, OH 43210
Phone: (614) 293-8714 Fax: (614) 293-4281

Patient Consultation Form

I request Dr. ________________ to see my patient, ________________________ (Patient name),

in consultation for the condition(s)/diagnosis(es): ______________________________.

Signed _________________________ Date ___________________
Requesting physician

PATIENT INFORMATION

Name: ____
DOB: ____
SSN: (optional) _________________________________
Address: ______________________________________
____
Home phone: _________________________________
Other phone: _________________________________

Insurance: ____________________________________
Policy #: ____________________________________
(If BWC, please include claim #, MCO and approved Dx codes)

PHYSICIAN INFORMATION

Name: ____
Address: ______________________________________
____
Phone: ______________________________________
Fax: ____
Office Contact: ________________________________