



Date ____ / ____ / ____
 Location: GB AP OSH

Request for Patient Services

Please complete all questions before faxing

1. Physician requesting services _____
 Telephone _____
2. Please **check** requested specialty and **circle** physician preference, if any.
 Physiatry *Dr. Hendricks Dr. Revord Dr. Schultz Dr. Sellers Dr. Staehler No Preference*
 Surgery *Dr. Greene Dr. Ullrich Dr. Wascher No Preference*
3. Are you interested in having surgery? Yes No
4. Please indicate service requested:
 A. Advice or opinion requested; return patient with report and
 assume management for this specific problem.
 B. Advice or opinion requested; return patient with report and
 make recommendations for management for this specific problem.
 C. Assume responsibility for the patient's complete care in advance, no report will be sent.

5. Patient information:

First name	MI	Last
Street	City	State Zip
Date of Birth _____ <small>mo/day/year</small>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
SS# _ _ _ / _ _ / _ _ _ _	Home Phone _____	Daytime Phone _____

Primary Care Physician _____

Work related injury? yes no Date of injury _____
 Auto accident? yes no Date of accident _____

Primary Insurance _____ Secondary Insurance _____

To assist in scheduling appointments promptly, please complete the information in the boxes below, OR fax medical records relating to the problem, along with this form to the fax number at the bottom of the page.

Patient symptoms? How long have these symptoms existed?	Which treatments have been tried by the patient? <i>(check all that apply)</i> <input type="checkbox"/> Chiropractic <input type="checkbox"/> Physical therapy <input type="checkbox"/> Injections <input type="checkbox"/> Medications
Has the patient had previous back or neck surgery?	What diagnostic tests has the patient received? <input type="checkbox"/> X-ray <input type="checkbox"/> MRI <input type="checkbox"/> MRA <input type="checkbox"/> CT <input type="checkbox"/> EMG <input type="checkbox"/> Bone Scan