

REFERRAL FORM

To refer patients to the UCSF Spine Center: Review the checklist below to determine whether your patient should be seen at our clinic, then follow the instructions at the bottom of this page to submit your referral.

When to refer:

Refer your patient if spine imaging reveals a surgical spine problem or deformity that requires surgical intervention. To prevent delays in referral review and care, please include the following records with your referral.

When to refer:

1. Spine MRI/CT **within the last 12 months**

We will need an MRI/CT report for referral review.

MRI/CT images will be needed for consultation once the referral is accepted.

*Please be aware the **MRI/CT report** and **imaging on CD** are two separate items. Once an appointment is scheduled, we will advise the patient on getting us images for consultation.*

2. Demographics information, including name, DOB, home address, phone number and caregiver information.
3. Insurance information with required insurance authorization for HMO-managed care patients and workers' compensation patients.
4. Additional diagnostic workups, including:
 - a. EMG reports
 - b. Physical therapy reports
 - c. Spinal injections procedure reports
 - d. Prior pain management consults (not required, but helpful)
 - e. Prior spine surgery reports (not required, but helpful)
 - f. Any other relevant spine imaging reports

Please note that following your submittal, we review all spine referrals for accuracy and work with your patient to get them rapidly evaluated.

Complete the back of this form and submit with accompanying records and diagnostic image reports to:

Attn: New Patient Coordinator
UCSF Spine Center
400 Parnassus Ave., 2nd floor, Suite A2300
San Francisco, CA 94143
Phone: (415) 353-2739

Neurospine fax: (415) 353-2176

Orthospine fax: (415) 353-4047

FOR NEUROSPINE PRACTICE ONLY

For any questions regarding new patient referrals, please call our new patient coordinators below **based on the first letter of the patient's last name**:

Letters A-I: (415) 353-2380

Letters J-Q: (415) 514-5766

Letters R-Z: (415) 353-2032

REFERRAL FORM



Thank you for choosing to refer your patient to UCSF. To start the referral process, please complete this form and fax it directly to the clinic.

- To find a clinic fax number, search at [ucsfhealth.org/refer-a-patient](https://www.ucsfhealth.org/refer-a-patient).
- Send brief, pertinent medical records, including test results and imaging, that support the consultation.
- Send a copy of the patient's insurance card (both sides) and HMO authorization if required.
- For help referring a patient, call (800) 444-2559.

Date	From
No. of pages	Title
To UCSF Spine Center Check one	Phone
<input type="checkbox"/> Orthospine <input type="checkbox"/> Neurospine	Fax

Neurospine fax: (415) 353-2176

Orthospine fax: (415) 353-4047

PATIENT INFORMATION

Name of patient _____

DOB _____

Home phone _____ Work phone Cell phone

Parent or caregiver _____

Address _____

City _____ State _____ Zip _____

Insurance _____

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-9/10 _____

Name of UCSF MD (if known) _____ Specialty _____

Reason for consultation _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD _____ Specialty _____

Phone _____ Fax _____

Primary care provider _____ Phone _____

Signature _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.