CRMC
CUYUNA REGIONAL MEDICAL CENTER
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PATIENT LABEL HERE

Spine Patient Referral Form

Fax to (218) 546-4414 ATTN: Scheduling

Today's date: ____/____/_____ # of pages (including this one): _____

Referral Source Information

Referring Physician/Provider: _____

Referring Clinic: _____ Phone: ____ - ____ - _____ Fax: ____ - ____ - _____

Patient Information

Patient Name: _____ ❒ Male ❒ Female

Date of birth: ____/____/_____ Patient main phone: _____ - _____ - _____ Alternate phone: _____ - _____ - _____

Type of insurance: _____

Reason for referral

Chief complaint: _____

☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Other: _____

Imaging: ☐ Xrays ☐ CT ☐ MRI ☐ Bone Density ☐ Other: _____

Information to include

☐ Most recent chart note(s)

☐ Image reports (all referred patients should have completed an MRI or CT of affected area.)

☐ Injection reports

☐ PT notes

Please fax all notes, reports and other pertinent documentation. Use this form as a cover sheet. All patients will be contacted by our office in 24-72 hours upon receipt of referral. All imaging should be pushed to our facility or a mailed CD.

Cuyuna Regional Medical Center
ATTN: Spine Scheduling
320 East Main Street
Crosby, MN 56441

Thank you for your referral!