

MAYFIELD Fax Referral Form – Physical Medicine & Rehabilitation

Please complete the form and fax along with last office note, EMG, MRI, and any other pertinent imaging studies. Fax to 513.684.4501. Our office will contact the patient for an appointment.

For phone in referrals, call the physician's office directly. Office Hours: 9:00 am to 5:00 pm.

Dr. Donald Carruthers 513-569-5328
Dr. Matthew Merz 513-569-5352
Dr. Marc Orlando 513-569-5399

Dr. Robert Whitten, MD 513-569-5280
Dr. Steven Wunder 513-569-5330

Patient Information:

Patient Name: _____ D.O.B. ____/____/____

SS # _____ Phone #: _____

Address: _____

Patient Insurance: _____
(PLEASE INCLUDE COPY OF FRONT AND BACK OF INSURANCE CARD)

Referring Diagnosis: _____

Testing (past 6 months): X-ray MRI CT Scan EMG Bone Scan
Other Testing: _____
(PLEASE INCLUDE COPY OF TESTING REPORTS IF POSSIBLE)

Referring Physician Name: _____

Referring Physician Phone #: _____ Fax # _____

Office Contact Person: _____

Sender Name: _____

Please check preferences:

- Consult & Treat
- Consult & return with recommendations
- EMG
- Spinal Stim Consult
- Injection series (must complete the following)

<input type="checkbox"/> Lumbar	Level(s): _____	Circle one:	Left	Right	Bilateral
<input type="checkbox"/> Cervical	Level(s): _____	Circle one:	Left	Right	Bilateral
<input type="checkbox"/> Thoracic	Level(s): _____	Circle one:	Left	Right	Bilateral
<input type="checkbox"/> Nerve Block	Level(s): _____	Circle one:	Left	Right	Bilateral
<input type="checkbox"/> Joint	Specify: _____	Circle one:	Left	Right	Bilateral

After injection, patient to follow up with: Referring physician Mayfield PM&R

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