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. Robert Whitten, MD	513-569-5280
Dr. Matthew Merz	513-569-5352	Dr. Steven Wunder	513-569-5330
Dr. Marc Orlando	513-569-5399		

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)

☐ Lumbar	Level(s): _____	Circle one:	Left	Right	Bilateral
☐ Cervical	Level(s): _____	Circle one:	Left	Right	Bilateral
☐ Thoracic	Level(s): _____	Circle one:	Left	Right	Bilateral
☐ Nerve Block	Level(s): _____	Circle one:	Left	Right	Bilateral
☐ Joint	Specify: _____	Circle one:	Left	Right	Bilateral

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