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*Diplomats of the American Board of Neurological Surgery

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Date: _____

Number of Pages: _____

Facility: _____

Attn: _____

Address: _____

Fax #: _____

Phone #: _____

REFERRAL FORM

To make a referral to Anchorage Neurosurgical Associates, Inc., please complete this form and fax it to our office at (907) 258-6247 with medical records and the imaging reports.

Doctor referring to (if none selected, the referral will be given to the Physician on call on the date of the referral):

___ Le He, M.D. ___ James Bales, M.D., Ph.D. ___ Jennifer Sokolowski, M.D., Ph.D. ___ Erik Kussro, D.O.

Patient Name: _____

Phone: _____

Representative: _____

SSN: _____

Insurance: _____

Date of Birth _____

WC _____ MVA _____ Other _____

(ANAI does not see patients with Federal WC. ANAI does not bill MVA claims)

Reason for Referral: _____

Studies: ___ MRI ___ CT ___ X-rays ___ Physical Therapy ___ EMGs Other _____

Has the Patient had prior surgery in this area? ___ Yes ___ No If so, ANAI needs films and reports.

Referring Doctor: _____

Date of Referral: _____

Address: _____

Phone: _____

Fax: _____

Form completed by: _____

Phone: _____

Once ANAI receives this form, the medical records (please include all records pertaining to the reason for patient referral and any other physician's records), and the actual imaging, the ANAI Physician will be given the material for review. No reviews will occur until all records and appropriate studies have been received. If after review, it is determined the patient needs to be seen for evaluation, we will contact the patient for an appointment. If the patient does not need to be seen, we will contact your office.

THANK YOU for your referral! If you have any questions, please feel free to call our office.

Confidential Health Information Enclosed: Health care information is personal and sensitive. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure without additional patient consent or authorization or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under federal and/or state law.

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* Please contact [AnchorageNeurosurgical](mailto:AnchorageNeurosurgical@anai.net) at (907) 258-6999 to verify the receipt of this fax or to report transmission problems. *