John L. Trotter M.S. Center Referral Request Documentation

660 South Euclid Avenue, Campus Box 8111, St. Louis, MO 63110 314-362-3293

Note: We need **medical records for review** and this form with all sections completed before any new patient will be scheduled. **FAX these to us at 314-362-0338**

Please be sure your patient has a copy of their MRI to bring to the appointment

___ **Records Received, Date of receipt**________

Patient: Address: DOB: SSN: Phone: Work:	Referring Doctor: Phone: Fax:

1. **Insurance Information **Required – (we cannot schedule without)**

   ____

2. **Referring Diagnosis or Problem**:______________________________

   ____

3. **Specific question** to be addressed?______________________________

   ____

   ____

4. **Doctors Only**: If you feel this is urgent, please leave your daytime contact information____

5. **Please check one of the boxes below**:

- ☐ Consultation/2nd Opinion only: send recommendations back to referring physician.
- ☐ Assume all care related to this problem (patients with MS or neuromyelitis optica only).
- ☐ Other:____

6. To which MS specialist are you referring this patient?

- ☐ First available ☐ Rob Naismith, MD ☐ Gregory Wu, MD (Consults / 2nd Opinion only)
- ☐ MS Fellow (supervised by Drs. Anne Cross, Becky Jo Parks, or Robert Naismith)

7. Choose One (method of scheduling):

- ☐ MS office to schedule appt directly with patient (please FAX patient contact information with records). Notify referring physician when scheduled? __YES __ NO
- ☐ *or* MS office to Contact referring referring physician's office to schedule appointment.

8. Referring MD Signature: ______________________ Date:____________