John L. Trotter M.S. Center Referral Form

Please send relevant **medical records and MRI report** with this completed form to help us expedite an appointment for your patient. **FAX these to us at 314-747-4629**

Appointment phone: 314-362-3293, option 2. Leave daytime # and times patient can be contacted if known.

Patient name: DOB: Phone #: Home Cell Work	Referring Doctor name: Phone: Fax:

1. **Insurance Information **Required**** – (Attach copies or write in information.)

   _____

   _____

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

   _____

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

   _____

4. **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:_____

5. **Healthcare Providers:** Please advise your patient to bring their MRI on a CD to their appointment (unless MRI done at BJC network hospital).
6. **Referring Signature**: _____ Date: _____

MS Center use only:

Date records received: _____

□ Referring MD clinical notes	□ have	□ need	
□ MRI report	□ have	□ need	
□ Blood tests	□ have	□ need	
□ LP results	□ have	□ need	□ not done

Date records reviewed:_____
Notes: