Baylor Scott & White
SCOLIOSIS CENTER

PHYSICIAN REFERRAL FORM

FAX TO 469-814-5699

PLEASE PROVIDE AND ATTACH INSURANCE INFORMATION & CLINICAL NOTES

DATE OF REFERRAL

REFERRING PHYSICIAN | **PHYSICIAN CONTACT NUMBER** | **PHYSICIAN FAX NUMBER**

PATIENT NAME | **PATIENT CONTACT NUMBER** | **ALTERNATE NUMBER**

DATE OF BIRTH | **DIAGNOSIS & ICD CODE** | **OTHER DIAGNOSIS & ICD CODE** | **OTHER DIAGNOSIS & ICD CODE**

PREFERRED PHYSICIAN: ☐ JEREMY DENNING, MD ☐ JASON TAUB, MD ☐ FIRST AVAILABLE APPOINTMENT

REASON FOR REFERRAL:

☐ NEW PATIENT SCOLIOSIS

☐ NEW PATIENT GENERAL SPINE

☐ EVALUATE AND TREAT

☐ OTHER: _____

INTERVENTION TARGET / MISCELLANEOUS NOTES:

PHYSICIAN SIGNATURE: _____

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