DESERT INSTITUTE FOR SPINE CARE

1635 E. Myrtle Avenue, #400 Tel: 602-944-2900
Phoenix, AZ 85020 Fax: 602-944-0064

Anthony T. Yeung, MD, PC
Christopher A. Yeung, MD
Justin S. Field, MD
Nima Salari, MD
Chad White, PA-C
Andrew Kuhlman, PA-C
Jennifer Keathley, PA-C

# OUT OF STATE CONSULTATION REQUEST FORM

## WHAT IS REQUIRED?

***All the following information needs to be submitted, along with patient registration form and fee for $250.00, prior to making any surgical arrangements. Once you have completed this process and your records are reviewed by one of our doctors, he will indicate a diagnosis and recommend a treatment plan. If you are a suitable candidate for out-patient minimally invasive surgical treatment, you will be contacted by one of our surgical team members to discuss making arrangements for your visit. Please address all the questions to the best of your ability. If the information is not complete, this can delay making arrangements for your arrival and treatment. If a particular question does not pertain to you, just place "N/A" for non-applicable.***

How did you find out about us? Referring Physician? Internet? _____

Your Full Name: _____ Date of Birth: _____
Male ○ Female ○ Home Phone: _____
Social Security Number: _____ Cell Phone: _____
E-Mail Address: _____ Fax Number: _____

Home Address: _____ Mailing Address: _____
_____ _____

Employer Name: _____
Work phone: _____ Occupation: _____
Brief description as to what type of work you do and/or what your job requires you to do:
_____
_____
_____
_____

Please submit a brief history of your back/leg complaints:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Please include which side is more painful, whether you have back pain, leg pain or both and which is worse, the back or the leg.**

Right side is worse ○ Left side is worse ○

What is your back pain to leg pain ratio? (i.e., 100% / 0% leg)

| | | | | | |
|---|---|---|---|---|---|
| B/L 100/0 ⊙ | B/L 90/10 ○ | B/L 80/20 ○ | B/L 70/30 ○ | B/L 60/40 ○ | B=L 50/50 ○ |
| B/L 40/60 ○ | B/L 30/70 ○ | B/L 20/80 ○ | B/L 10/90 ○ | B/L 0/100 ○ | |

Is this a work related injury? _____ Is this a non-work related injury? _____
Is this related to a motor vehicle accident? _____ Did your symptoms begin gradually or suddenly, without injury? _____

Include what type of treatment you have had, what duration, medications, and diagnostic procedures. _____
_____
_____
_____
_____.
Have you had surgical treatment for your condition? _____ What was this surgical treatment and when? _____
Did this treatment help you? _____ If yes, how long? _____

We will need copies of the medical and operative reports, if available, if you have had surgical treatment for your back condition, **and the MRI Scan, Myelogram/CAT Scan study, X-rays, Discography reports, as well as these films.** Do not attach images of these studies if you e-mail us as it takes a great deal of time to download them because of their enormous file size.

What medications are you currently taking for your present back/leg problem? _____
_____
_____
_____

Please describe your prior and current general medical history, **other than your back/leg problem**, including what surgeries you've had and dates, and if you experienced any complications:_____
_____
_____
_____
_____
_____
_____
_____

What medical treatment are you **CURRENTLY** under going? **OTHER** than for your back/leg condition and for what diagnosis: _____

What **OTHER** medications do you take for any **OTHER** medical condition you are experiencing possibly described above: _____

What is your current height and weight? _____ Do you smoke or use tobacco products? _____ If yes, how long, how much and how often? _____

Do you consume alcohol? _____ If yes, how much and how often? _____

Describe any allergies you have to any medication or other allergies including possibly tape, metals, radiographic dyes, etc: _____

**If YOU have private insurance and this is a group policy through your work,** please submit the name of your employer or company, phone number and fax number: _____

If your spouse or significant other is the cardholder, please submit that person's:

Name and relationship: _____
Social Security # _____ Phone #: _____ Cell phone: _____
FAX #: _____ E-mail Address: _____ DOB: _____
Name of Cardholder as it appears on your insurance card: _____

**If you have private insurance**: please submit this information, including an enlarged copy of the front and back of your insurance card.

Name, address of insurance carrier: _____

_____

Phone number for member/customer services for benefit/coverage of insurance carrier: _____

_____

Phone number for pre-cert authorization, utilization review of insurance carrier: _____

_____

Identification/account number on insurance card: _____

_____

Group or policy number on insurance card: _____

Effective date of insurance coverage: _____

If you have a managed care policy such as an HMO, EPO, please indicate name of primary care physician and phone number: _____

_____

If **MEDICARE** is your primary insurance, **presently Medicare does not always cover the Squaw Peak Surgical Facility fees.** In this instance, Medicare requires that you sign an Advanced Beneficiary Notice (ABN) form, acknowledging your responsibility for any fees not covered.

**Payment for any non-covered fees will be required at the time services are rendered.** Financial arrangements/options can be discussed with our Patient Care Coordinator, at (602) 216-6904.

Medicare card number: _____ Issue/effective date: _____

**If this is a work related injury**, you or your treating physician/primary care physician may need to obtain a referral to our doctors to be seen and evaluated as well as an authorization for surgical treatment.

Claim number/policy number/identification number: _____
Date of injury: _____ Name, address and phone number of employer at time of injury: _____

_____

Name, address, phone number and FAX number of industrial carrier: _____

_____

_____

**If this is related to a motor vehicle accident:** Name of insurance carrier: _____

_____

Address of carrier: _____

Phone number, FAX number of carrier: _____

_____

Name of policyholder: _____

Name of claimant: _____

Policy/claim number: _____

Date of accident: _____

**If you have retained an attorney** because of your work injury or motor vehicle accident: Name of attorney: _____ Address: _____

_____

Phone and fax numbers: _____

**For our office to release any information to your attorney or representative, we require that you provide a signed and dated release of information request form from your attorney.**

If you have a spouse, significant other, "life partner" in case of an emergency, please submit his/her/their phone numbers, cell numbers, fax or e-mail address. If this person will be accompanying you to visit our doctors, please indicate. **It would be better if someone accompanies you when you visit us, if possible.**

Name of Person and Relationship to you: _____

Best way to contact this person: _____

Phone number: _____ Cell phone: _____

FAX number: _____E-mail address: _____

Once the above information has been returned and reviewed by one of our doctors, if it is determined that you are a suitable surgical candidate, the doctor will then provide you with a letter explaining the diagnosis and his treatment recommendations. Your insurance information, if received, will be verified and your benefits and financial obligation will be researched. This will then be discussed with you. If a pre-cert authorization is required for this out-patient procedure, we will attempt to obtain this authorization. After the above has been completed, a pre-op clinical evaluation will be arranged as well as the surgical date.

Generally, we would have you seen by one of our doctors on a given day, surgery the following day; you can leave within two days after surgery, after your doctor has examined you post-operatively. Your films will be returned to you then as well. **Again, do not make ANY reservations for airline tickets or hotel until you have been given a definite pre-op evaluation date and a surgical date.** You may need two weeks notice to the airlines to obtain a reasonable airfare. You may, of course, research this in advance and every effort will be made to accommodate your request if the surgical timeframe is available.

If you have any medical questions, you can e-mail our Physician Assistant, Andy Kuhlman, at akuhlman@sciatica.com.