



SRMC Neurosurgery Clinic Phone: (505) 994-7336 Fax: (505) 994-7256

**External Referral / Consult Request Form**

**Instruction:** The following information will be required for review of your referral. Please submit complete packet to the fax number above and allow up to 8 days for review.

**Patient Demographics & Insurance Information**

- Please include patient name, address, best contact number, insurance name & policy number

**Contact information for PCP and/or referring physician**

- Please include address, phone and fax number

**Consult Request / Referral**

- What question do you need addressed by the specialist?

**Recent Clinic/Progress Notes**

- Last 3 visits (if applicable)

**Recent Diagnostic Reports** - Must be completed within last 12 months

- Diagnostic testing is required for all patients prior to referral. MRI is preferred.
- If you have questions regarding this, please call and speak to a nurse

**Current Medication List**

\*\*\*\*\*

**Patient Appointment Status** For UNM Hospitals Use Only

Appointment has been made with Dr. \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ am/pm

Not able to schedule appointment due to:  
\_\_\_ Incomplete information for