NEUROLOGICAL SURGERY ASSOCIATES EST. 1946

REFERRAL FORM

☐ James R. Adametz, MD ☐ Zach Mason, MD
☐ Robert Ingraham, MD ☐ Reza Shahim, MD

Date: _____ Referring Physician: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ DOB _____ SSN: _____

Phone: _____ Alt: _____

Address: _____

City/State: _____

Primary Insurance: _____

Policy/ID: _____ Group: _____

Secondary Insurance: _____

Policy/ID: _____ Group: _____

Reason for Referral: _____

Previous back or neck surgery? _____ Year: _____

Due to Motor Vehicle Accident? _____ Work-Related Injury? _____

Please include the following information along with this referral sheet:

- Most recent clinic note(s)
- Radiological imaging reports (MRI/CT/XR or EMG)

Please fax referrals: (501) 225-5694 or email: nsareferrals@neurologicalsurgergyassoc.com

We will contact the patient with appointment information and will also notify you of this appointment by fax.
Thank you for your referral and trust.

5201 Northshore Drive, Suite 100, North Little Rock, Arkansas 72119
Phone: (501) 225-0880 | Fax: (501) 225-5694