William H. Megdal, M.D.
Benjamin E. McCurdy, M.D.
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(706) 425-2400 Phone
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CONSULT REQUEST

Date______________________________

Requestor__________________________ **Practice Name**__________________________
Referring Physician____
PCP____

Diagnosis____

Consult Requested for ____________________________________

Most Recent MRI Related to Condition__________________________

Previous Pain Management Treatment? ☐ **Yes** ☐ **No**
If yes less than 5 years, Letter of Release/Transfer/Discharge Required

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Date and Time Preferred [ ] **No Preference / First Available** [ ]__________________
Doctor Preferred [ ] **No Preference / First Available** [ ] **Dr Megdal** [ ] **Dr McCurdy**

Patient Information

Patient Name____________________________________**DOB**__________________
Contact Info **H**____________________ **C**____________________________
W____________________ **Email**__________________________

Insurance Name ______________________________________ ❑ **Workers Comp?**
Insurance Address____

Insurance Phone ____________________ **Contact Info**______________________
Policy ID ________________________ **Claim Number** ____________________
Employer Name ______________________________ **Phone**__________________
(All above insurance information is required for workers compensation)

Referral____________________❑**N/R** **Authorization**________________❑**N/R**

Additional Information____

- ❑ **Medical Records Attached**
- ❑ **MRI report(s)**
- ❑ **Patient Advised of Appointment**
- ❑ **Patient Advised to Arrive Early**
- ❑ **Patient Advised to Bring Meds/List**

Signed__________________________________
I have read and understand the referral guidelines
(Physician/Nurse/Office Representative)