FOCUSED ULTRASOUND REFERRAL

SEMMES MURPHEY
Leaders in Brain & Spine Care

Dr. Benjamin W. Carroll

DATE:		CONTACT:	
FAX:	833.449.3605	REFERRING MD:	
PHONE:	901.522.7700	PHONE:	FAX:
		ADDRESS:	

Patient Name: ______________________________ DOB: ___________ PHONE: _________________________

Address____

Insurance:____ ID:___________________________________

Does the patient have a diagnosis of Essential Tremor? (G25.0)	___ Yes	___ No
Does the patient have a diagnosis of Parkinsons? (G25.1)	___ Yes	___ No
Has the patient had any imaging?	___ Yes	___ No
Has the patient trialed 2 medications? If yes, what medications: ___________________________________		

Please attach a demographic sheet, copy of health insurance card (carrier/ID), treatment notes and imaging reports.

____ ____________________________________

Referring provider's signature Date

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