Fast Track Scheduling Referral

(Please select doctor)

__ Dr. Timothy J Burkhart

__ Dr. James A Chapp

__ Dr. Ryan M Burkhart

After calling our office to make an appointment, please fax this completed form to our scheduling department at 616.698.2188. Thank you for the referral.

Patient Name: ____ Date: ______________________________________

Social Security #: _____-____-______ Date of Birth: ___/___/___ Phone #: ___________________________________

Referring Physician: ____________________________________ Phone #:__________________________

Referring Office Contact: _______________________________ Fax #: ____________________________

Patient's Current Diagnosis: ____

Reason for Referral:

___Evaluate Only ___Candidate for Cervical Spinal Decompression

___Evaluate and Treat ___Candidate for Lumbar Spinal Decompression

___Other: ____

Previous Studies/ Treatments and Location were performed:

__X-Rays When? _______________ Where? ____

__CT Scan When? _______________ Where? ____

__Discogram When? _______________ Where? ____

__Pain Management When? _______________ Where? ____

__MRI When? _______________ Where? ____

__Oth____

__Previous Back Surgery? ___Yes ___No If yes, where and who? ____

__Face Sheet included with this fax referral sheet

__Insurance information is included with this fax referral sheet

OR

__ See Insurance Information Below

Marital Status: ___Single ___Married ___Widowed ___Divorced

Spouse's Name: ____

Patient Address: ____

Employer: ____

Is this work or Auto related? ___No ___Yes If yes, please provide Claim No________________________

Date of Injury: ____________________ Insurance Carrier: ______________________________

Adjuster Name: ____________________ Phone #: ______________________________

Primary Insurance: ____

Contract Number: __________________ Insured Name: ______________________________

Group Number: ____________________ Insured's Date of Birth ___/___/_______

Employer: ______________________________

Secondary Insurance: ____

Contract Number: __________________ Insured Name: ______________________________

Group Number: ____________________ Insured's Date of Birth ___/___/_______

Employer: ______________________________

BCC Office Use Only

Appointment Date: ____/_____/______ Time: __________ With Dr.______________________________