Baylor Medicine

NEUROSURGERY

BAYLOR MEDICINE
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PATIENT REFERRAL FORM

Patient Name: _____ DOB: _____

Home #: _____ Cell #: _____

Referring Physician: _____

Request a Physician: _____ OR ☐ First Available

Please Schedule:

☐ New Patient Consultation for Possible:

Neurovascular Surgery Evaluation
- ☐ Cerebral Angiography
- ☐ Endovascular Procedures
- ☐ Open Neurovascular Surgery

Functional and Pain Neurosurgery
- ☐ Deep Brain Stimulation
- ☐ Epilepsy Surgery
- ☐ Trigeminal Neuralgia
- ☐ Pain (Pain Pump/Stimulators)

Cranial Neurosurgery Evaluation
- ☐ Brain Tumors
- ☐ Chiari Malformations
- ☐ Hydrocephalus
- ☐ Skull Base Surgery
- ☐ Pituitary Tumors
- ☐ Acoustic Neuromas
- ☐ Other _____

Spinal Neurosurgery Evaluation
(spine imaging from last 12 months required)
- ☐ Spinal Tumors
- ☐ Degenerative Spine
- ☐ Spinal Instability
- ☐ Disc Disease

☐ Peripheral Nerve Surgery
☐ Stereotactic Radiosurgery
☐ Other _____

☐ Follow Up Appointment

TO SUBMIT THIS FORM PLEASE FAX 713.798.3739 OR EMAIL NEUROSURGERY@BCM.EDU

Please include medical records with your submission and note that providers who opt to email this form must send it using an encrypted email.

For an up-to-date list of accepted insurances, please visit:
baylormedicine.org/insurance