



GREAT LAKES  
**NEUROSURGICAL**  
ASSOCIATES, P.C.

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## NEW PATIENT REFERRAL FORM

Physician Requested:  David W. Lowry, M.D.  No Preference  
 Todd Vogel, M.D.

### PATIENT DEMOGRAPHICS

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Work Comp/Auto Insurance: \_\_\_\_\_

Insurance Authorization (if required): \_\_\_\_\_

### REFERRING PHYSICIAN INFORMATION

Requesting Provider: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_  
\_\_\_\_\_

Referring Physician Office Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### BASIC PATIENT HISTORY

Previous Surgeries: \_\_\_\_\_

Previous Studies/Imaging: \_\_\_\_\_

**PLEASE FAX RELEVANT OFFICE NOTES AND ALL IMAGING REPORTS THAT HAVE BEEN COMPLETED WITHIN THE PAST 12 MONTHS WITH THIS REFERRAL.**