



Remi Nader, M.D.

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PATIENT REFERRAL FORM

*****For all Brain or Spine Problems, Please HAVE PATIENT BRING Actual Imaging Films which Must Include MRI or CT scans (Films may be on CD ROMS) *****

Alternatively please mail the CDs and reports/ records to our correspondence address:

3431 RAYFORD RD. # 200-563 SPRING, TX 77386

Also, please bring office notes, reports, medication list, insurance cards.

Patient Name: _____	
Referred By: _____	
Phone Number: _____	Fax: _____
Email: _____	
Demographics: Age: _____ Sex: _____ Date of Birth: _____	Primary Insurance Info:
Patient Contact Info: Address: _____ _____ _____ Phone: _____	Secondary Insurance Info:
Brain/ Peripheral Nerve Pathology Diagnosis/Reason for Referral:	Spine Pathology Diagnosis/Reason for Referral:
Imaging/Studies Performed:	Imaging/Studies Performed:

**Please feel free to FAX or email form at:
1-888-847-6562 or Carmen@ICNSpine.com**

Office Phone: 832-932-9300