Michael Borrello. M.D.
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356 Mountain View Drive, Suite 200, Colchester, Vermont 05446

Thank you for your referral. We are pleased that you have selected Vermont Interventional Spine Center to assist your patient. To help us understand exactly what service you are requesting, please fill out this form completely.

Please fax or mail ALL relevant notes, including any note(s) from other consultations, reports, etc. so that we may properly schedule your patient.

Fax**: (802) 655-0002** Phone: **(802) 655-9798**

CONSULT REQUEST

Referring Physician: _____ MD Telephone # _____

Patient's Name: _____ DOB: _____

Patient Phone Number:_____Cell#_____

Patient's Insurance:_____ID#_____GRP#_____

Patient's
Address:_____

_____

_____

Consultation is for: _____

_____

_____

Has the patient had any of the following tests to evaluate their pain concerns/issues?

_____MRI _____X-Ray _____EMG _____Bone Scan _____CT Scan

If yes, please fax report or provide approximate date of test, and where it was performed:

_____

Is the patient currently taking any of the following:

Aspirin Coumadin/Plavix Anti-inflammatory Medications