HEARTLAND NEUROSURGERY

Russell Buchanan, MD Lynn Galloway PA-C Mary Ann Amend ARNP

Patient Evaluation Form

Please circle appropriate choice per requesting provider:

Evaluate & Advise (ie: opinion) **or** **Evaluate & Manage** (ie: treat the problem)

Requesting Physician's office _____
Associate name, phone & fax #_____

Has this patient been seen in our office before? Yes_____ No_____

Patient Name _____ DOB _____
Address_____
Phone Number _____

Please fax copy of current insurance card or provide insurance company name: _____

Is the patient's current medical issue related to the following?

Motor Vehicle Accident? Yes_____ No_____
Worker's Compensation Claim? Yes_____ No_____
In either of these instances, is there an attorney involved? Yes_____ No_____

Please describe patient's symptoms upon physician's exam:

_____
_____

Is there any weakness upon exam? Yes_____ No_____ if yes, please include Physician's note to support.

Are there any bowel or bladder changes related to this problem? Yes_____ No_____ if yes, please describe symptoms:

_____
_____

Please fax this completed form along with most recent MRI & X-ray reports to 319-226-9889. Once reviewed, we will call with scheduled appointment.

Appointment Date: _____ Time:_____ Provider:_____

*****Please keep a copy for your permanent records*****

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