



DATE: _____

PATIENT _____

Name and Date of Birth

PHONE #: () _____

OFFICE PHONE: (770) 590-1078 ext. 1121

FAX FORM TO: (770) 771-5620

DIAGNOSIS: _____

Hiram Office

David W. Gale, MD
NPI 1861505570

REFERRING PROVIDER: _____

Marietta Office

Thomas E. Hurd, MD
NPI 1659484327

CONTACT: _____

Woodstock Office

Michael K. Schaufele, MD
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Contact Name and Extension

Cartersville Office

Marvin D. Tark, MD
NPI 1548373210

*Please check appropriate box below that applies to this referral / consultation.

REQUEST OPINION ON / CONSULTATION : _____

TRANSFER OF CARE: _____

DIAGNOSTIC PROCEDURE: _____

THERAPEUTIC PROCEDURE: _____

**** PLEASE ATTACH RECENT OFFICE NOTES AND X-RAY REPORTS**

**** PLEASE ATTACH INSURANCE COMPANY REFERRAL/AUTHORIZATION (AS APPLICABLE)**

PRIMARY INSURANCE ID #: _____

SECONDARY INSURANCE ID #: _____

WORK COMP ADJUSTER: _____ PHONE NUMBER: _____

CLAIM NUMBER: _____ AUTHORIZED TREATING PHYSICIAN: _____

APPROVED REFERRAL: ___ YES ___ PENDING

COMMENTS: _____

NUMBER OF PAGES INCLUDING THIS PAGE: _____

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