



CENTRAL VALLEY ADVANCED SPINE

Devan Higginbotham, MD | Orthopedic Spine Surgery

Endoscopic | Minimally Invasive | Complex Spine

7206 N Milburn Suite 105 Fresno, CA 93722

SPINE REFERRAL FORM

Date _____

Phone **559-758-7119**

FAX REFERRALS TO **559-599-4536**

Fax this completed form with the records checked below. Confirm the fax number before sending.

PATIENT INFORMATION

Patient name _____ DOB _____

Phone _____ Alternate phone _____

Address _____

Preferred language _____ ☐ Interpreter needed

REFERRING PROVIDER

Provider name _____ NPI _____

Practice _____

Phone _____ Fax _____

Contact person _____ Direct phone _____

REFERRAL DETAILS

☐ Routine ☐ Urgent - call clinic to discuss Requested timing _____

☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Deformity ☐ Other

Diagnosis / ICD-10 _____

Reason for referral / symptoms / duration _____

☐ Consultation ☐ Surgical evaluation ☐ Second opinion

INSURANCE AND AUTHORIZATION

Primary plan _____ Member ID _____

Secondary plan _____ Member ID _____

☐ Authorization attached ☐ Not required ☐ Pending Auth # _____

Workers comp carrier / claim # if applicable _____

Adjuster name / phone if applicable _____

RECORDS TO INCLUDE

☐ Demographics / insurance cards ☐ Relevant office notes / treatment history

☐ MRI / CT / X-ray reports ☐ Prior spine operative reports if applicable

Imaging facility / exam date _____

Please arrange access to actual imaging. For emergencies, use emergency services; do not rely on fax.

CONFIDENTIAL PATIENT INFORMATION - Intended for the receiving clinic only.