



Anchorage Neurosurgical

— ASSOCIATES INC. —
BRAIN | SPINE | NERVES | EST. 1981

3831 Piper Street Suite S-450 Anchorage, Alaska 99508 Phone (907) 258-6999 Fax (907) 258-6247

REFERRAL FORM

Date of referral: _____

Please check who you would like to refer to (if none selected, the referral will be given to the Physician on call on the date of the referral):

**Diplomate of the American Board of Neurological Surgery*

☐

Louis L. Kralick, MD*

☐

Benjamin P. Rosenbaum, MD*

☐

Le "Lucy" He, MD

☐

James W. Bales, MD, PhD

☐

Erik Kussro, DO

To make a referral to Anchorage Neurosurgical Associates, Inc. please complete this form and fax it to our office at (907) 258-6247 with medical records and imaging reports.

Referring Provider: _____

Phone #: _____

Fax #: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone #: _____

Reason for Referral:

(Please include reports/records)

Studies patient has: ☐ X-ray ☐ CT ☐ MRI ☐ EMG ☐ Physical Therapy ☐ Injection

Other: _____

Has the patient had prior surgery in this area? YES NO If yes, please provide images and reports.

Please provide patient insurance information here.

Primary Insurance Carrier:

Secondary Insurance Carrier:

I.D. Number:

I.D. Number:

Group Number:

Group Number:

Insured Person and Date of Birth:

Insured Person and Date of Birth:

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