Arrowhead Neurosurgical Medical Group, Inc.

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Treating Physician Remote Second Opinion/Referral Form

Name of Patient: _____

Date of Birth: _____

I request Arrowhead Neurosurgical Medical Group, Inc. to provide a remote second opinion for the above patient. I have discussed this request with my patient, and he/she understands the risks and limitations of this service. I will provide my patient with copies of their medical records and any other relevant imaging, reports and/or studies to provide to ANMG. I understand that the written second opinion report will be sent to me, and I will review it with my patient. I also acknowledge that I am a licensed physician in the state/country in which my practice is located and in which the patient resides.

Signature: _____ Date:_____

Treating/Referring Physician Name: _____

Name of Practice: _____

Street Address: _____

City: _____ State/Country: _____

Zip: _____

Office Phone: _____ Office Fax: _____

****Patient:** Once complete, please send the treating physician referral along with your records, completed questionnaire and signed consent form as attachments via email (secondopinion@anmg-ca.com) or fax to the number listed in our website: www.anmg-ca.com/secondopinionprogram. Please be reminded that the NON-REFUNDABLE FEE is due PRIOR to any generation of a second opinion report. Please refer to the ANMG Second Opinion Consent Form for more information regarding rights, responsibilities. and limitations of the program.