EMORY
HEALTHCARE

Treating Physician Remote Second Opinion Form

Name of Patient: _____

Date of Birth: _____

I request Emory Clinic Department of Neurosurgery 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 Emory. 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 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: _____ 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 the Emory Blue Patient Portal, or fax them to us at 404-778-3279.