

Refer your patients to the advanced spine care services at St. Joseph Health



What sets us apart:

- World-class, immediate spine care in a collaborative effort with the Department of Neurological Surgery at the University of California, San Francisco and UCSF Medical Center
- Board-certified neurosurgeons who are highly experienced in all types of spine surgeries and use minimally invasive techniques whenever appropriate
- Complete back and spine care, including back and neck surgeries, spine cancer care, a spine injury rehabilitation program and spinal cord trauma care

St. Joseph Health 
Queen of the Valley

What we offer:

- Minimally invasive procedures allowing a smaller incision, reduced pain and faster recovery time
- A team of physical therapists, occupational therapists and rehabilitation experts who provide advanced care
- Personalized treatment and rehabilitation program uniquely designed for your treatment needs

For more information, call 707-522-4335

Or fax referral form to: 707-303-9250



Regional Referral Form For Physician Completion

Thank you for choosing St. Joseph Health. To start the referral process, please fax this form to the service line to which you are referring your patient.

- Please fax to 707-303-9250
- Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call 707-522-4335

Date:	From:
No. of pages:	Title:
Service Line:	Phone:
Fax:	Fax:

Patient Information

Name of patient: _____

DOB: _____ Interpreter needed: ☐ Yes ☐ No Language: _____

Home phone: _____ ☐ Work or ☐ cell phone: _____

If child, name of parent: _____

Address: _____

City: _____ Zip: _____

Insurance: **Please include patient's insurance card (both sides), HMO authorization if required and images of affected area.**

Office Notes: _____

Consultation Request Information

Diagnosis/ICD10: _____

Name of St. Joseph Health MD (if known): _____ Specialty: _____

Reason for consultation: _____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaborating with you on your patient's treatment plan.

Referring Provider Information

Referring Provider:	Specialty:
Phone:	Fax:
PCP name:	Phone:

Signature: _____

NOTICE OF CONFIDENTIALITY: This is a confidential fax and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this fax and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.