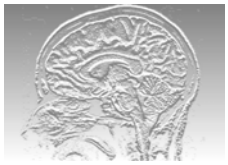

Houston MicroNeurosurgery

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What is Self-Referral Screening?

New patient appointments are scheduled by referral from a physician within the referral base of Houston MicroNeurosurgery. Otherwise, patients who wish to refer themselves are required to undergo a Self-Referral Screening to determine if they will receive an appointment at Houston MicroNeurosurgery. The screening process is free of charge.

How does the screening process work?

To qualify for the screening process, you **must have had an MRI or CT scan** of the symptomatic region of your spine (or brain) within the past 12 months. You submit the required material (see the checklist below) to Houston MicroNeurosurgery by mail or in person. Dr. Pakzaban will personally review the material you have submitted. Within a few days, you will be notified by phone about whether you have been accepted for an appointment. If you have not heard from us within one week, you may call us to check on the status of your screening.

Self-Referral Screening Checklist

The following material should be submitted to Houston MicroNeurosurgery by mail or in person:

1. **MRI or CT images:** These can be submitted on a CD (preferable) or on printed film. These will not be mailed back to you. If you are not accepted for an appointment, you will be given one month to pick up the films in person.
2. MRI or CT **written radiologist report**
3. Completed **Self-Referral Questionnaire** (attached below)
4. Signed acknowledgement of the **Terms and Conditions of Self-Referral Screening** (attached below)

Self-Referral Questionnaire

Name: _____ Age: _____

Phone Number: _____ Alternate Phone Number: _____

Name and Phone Number of Primary Care Physician (if you have one):

_____

How did you hear about us? _____

Insurance Information: _____

(Your insurance will not be billed for this screening.)

Brief Description of Your Symptoms:

Please check all that apply below:

Pain Location:	☐ **Head**	☐ **Neck**	☐ **Mid-Back**	☐ **Low Back**
Pain Radiating to:	☐ **Right Arm**	☐ **Left Arm**	☐ **Right Leg**	☐ **Left Leg**
Numbness:	☐ **Right Arm**	☐ **Left Arm**	☐ **Right Leg**	☐ **Left Leg**
Weakness:	☐ **Right Arm**	☐ **Left Arm**	☐ **Right Leg**	☐ **Left Leg**

How long have you had these symptoms? _____

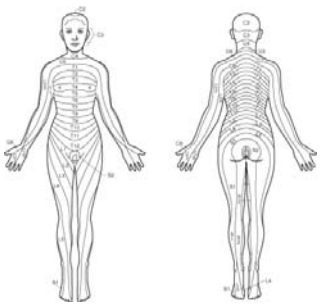
Have you had surgery for this or a similar problem before? Please explain:

_____

Have you had any non-surgical treatment for this problem in the past 12 months (e.g. medications, physical therapy, steroid injections)?

_____

After you print this form, mark or color the location of your pain on this diagram. If you wish, you may use a different color for the area of the numbness.



Terms and Conditions of Self-Referral Screening

Please read carefully and acknowledge your acceptance of these terms and conditions by signing below.

1. I understand that submitting a request for Self-Referral Screening to Houston MicroNeurosurgery does NOT establish a patient/doctor relationship between me and Dr. Pakzaban or Houston MicroNeurosurgery. Such a relationship will develop only if I have been accepted for an evaluation and only after I have undergone such an evaluation by Dr. Pakzaban.

2. I understand that if I am accepted for evaluation, this does not necessarily mean that I will undergo surgery. I understand that Dr. Pakzaban will make any decisions regarding surgery only after he has personally interviewed and examined me. Additional diagnostic tests, non-surgical treatment, or no treatment may be recommended.

3. I understand that I may not be accepted as a patient by Dr. Pakzaban. I further understand that no explanation will be provided as to why I have not been accepted for evaluation.

4. I understand that if I am not accepted for evaluation, I may still have a problem that requires medical attention. Such a determination can only be made by the physicians who have previously examined me and ordered my diagnostic studies. As such, I remain under their care.

5. I understand that if my condition suddenly deteriorates while I am undergoing the screening process, I will report immediately to an emergency room or to a doctor with whom I have previously established a patient/doctor relationship.

I fully understand and accept the terms of the Self-Referral Screening process as described above.

Name: _____

Signature: _____ Print, then sign! _____ Date: _____

For Office Use Only		
Date Received:	Complete: Yes / No	Date Completed:
Date Reviewed by PP:	Decision:	
Date Patient Informed:	Staff Member Initials:	