THE BOSTER CENTER
FOR MULTIPLE SCLEROSIS

8000 RAVINES EDGE COURT | SUITE 200 | COLUMBUS, OHIO 43235
PH. 614.304.3444 | FAX 614.304.3433 | INFO@BOSTERMS.COM

REFERRAL FORM

Thank you for choosing to refer your patient to the Boster Center for Multiple Sclerosis.
To start the referral process, please complete this form and fax it directly to the clinic.

- **Send brief, pertinent medical records, including test results and imaging, that support the consultation.**
- **Send a copy of the patient's insurance card (both sides) and HMO authorization if required.**
- **For help referring a patient, call (614) 304.3444**

Date _____ No. of pages _____

ATTN: _____ Phone/Fax _____

From _____ Title _____

PATIENT INFO

Patient Name: DOB:

Address: Gender Identity: ☐ M ☐ F ☐ Other

City: State: Zip Code:

Home/Cell: Work: Gurantor:

Insurance Company: Member Number: Group:

CONSULT REQUEST INFO.

ICD Code: Confirmed Diagnosis of MS: ☐ Yes ☐ No Date of Diagnosis _____ EDSS Score:

Type of MS/Condition:
☐ Relapsing-remitting ☐ Primary Progressive ☐ Secondary Progressive ☐ Unknown/Other _____ ☐ NMO ☐ Transverse Myelitis

Name of Current Provider: Specialty: Comment:

Date of Last MRI: MRI Facility: MRI Facility Fax:

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 PHYSICIAN INFORMATION

Referring Provider: NPI:

Phone: Fax: Signature:

Please fax form with notes to 614.304.3433 ATTN: Consults