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Fellowship Trained in Spine Surgery
Board Certified in Orthopedic Surgery

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Spine Consultation Request Form

Date: _____

Patient Name: _____ DOB: _____

Patient Phone Numbers: _____ (home)

_____ (work)

_____ (cell)

Consult with:

Dr. Reuben *or* Dr. Boatright

Dr. Boatright

Dr. Reuben

ASAP

ASAP

ASAP

Next Available

Next Available

Next Available

Please evaluate for: _____

(reason for consultation)

(Signature of Requesting Health Care Provider)

Please fax this form to our office at 843-522-1275. We will contact the patient and schedule their appointment. We will then give your office a return call confirming that we have scheduled the requested consultation. If you prefer, you may call our office directly at 843-379-SPINE(7746) to schedule this consultation. Thank you for allowing us to participate in the care of your patient.