



NEUROLOGY REFERRAL FORM

Patient name _____

DOB _____ Phone # _____ Cell # _____

Address _____

Insurance Carrier _____ Policy # _____

1. Is this an emergent neurological referral? No Yes (If yes, please explain)

2. Please describe the patient's chief complain and include onset and frequency.

3. What is the key question you would like us to answer?

To expedite appointment scheduling, please provide the following by fax **256-801-7893**:

- This completed form
- Medical Records related to chief complaint
- Prior neurology records including EEG, EMG, CT or MRI results
- Prior Authorization, or if not applicable, a copy of insurance card
- Most recent office note
- Pertinent lab/procedure results

REFERRING PROVIDER

Physician _____ Address/Location _____

Phone _____ Fax _____

Provider Signature _____

Appt. Date and Time _____

Patient notified on _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures