COMPREHENSIVE EPILEPSY PROGRAM
PATIENT CARE • EDUCATION • RESEARCH

EPILEPSY INSTITUTE OF NORTH CAROLINA
THE BRAIN IS WHERE YOU LIVE

NEW PATIENT REFERRAL FORM

Date: ____ /____ / 20_____

- ***FAX <u>COMPLETED</u> REFERRAL FORM, COPY OF INSURANCE CARD, AND <u>COMPLETE</u> MEDICAL RECORDS PERTAINING TO THE REASON FOR THE REFERRAL TO* 336-659-8206**
- ***UPON REVIEW AND APPROVAL, WE WILL THEN SCHEDULE AN APPOINTMENT WITH <u>THE PATIENT</u>.***

NOTICE: ***Neurological patients will receive a NEW PATIENT PACKET which is to be <u>completed AND returned to our office</u> BEFORE an appointment will be scheduled.***

PATIENT INFORMATION

LAST _____ FIRST _____ M.I. _____
ADDRESS _____ APT #_____
CITY _____ STATE _____ ZIP CODE _____
DOB _____/_____/_____ AGE _____ SEX: ☐ M ☐ F RACE _____
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline
SS #_____-_____-_____ DRIVER LICENSE # _____
PARENT NAME (if applicable) _____

CONTACT INFORMATION

CELL (_____) _____ - _____ * HOME (_____) _____ - _____
WORK (_____) _____ - _____ EMAIL _____

* *Appointment reminders may be sent to your mobile/cell number via text.*

INSURANCE/PRIMARY CARE PHYSICIAN INFORMATION

INSURANCE _____ ID# _____ GROUP _____
MEDICAID CAROLINA ACCESS # _____
PRIMARY CARE PHYSICIAN/FACILITY _____ NPI # _____

REFERRING OFFICE/AGENCY

REFERRING PROVIDER _____ PROVIDER NPI # _____
PHONE (_____) _____ - _____ FAX (_____) _____ - _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
DIAGNOSIS _____
Evaluate for:_____

REQUESTING APPOINTMENT WITH/FOR

☐ Neurologist ☐ Psychological Assessment ☐ Behavioral Assessment ☐ Therapy

Please check all areas of concern:

☐ Headache ☐ Anger or Violence issues ☐ Attention or Impulse Difficulties
☐ Seizures ☐ Behavior issues ☐ School failure due to behavioral issues
☐ Anxiety ☐ Depression ☐ Psychiatric Disorder
☐ Other _____

FOR OFFICE USE

Date information mailed to patient ____ /____ / 20_____ Received from patient ____ /____ / 20____
Provider to be seen: _____
Date/Time of appointment ____ /____ / 20_____ at _____ am / pm

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