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.***
- ***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
SS #_____-_____-_____ DRIVER LICENSE # _____
RACE _____ ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Decline
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 MD/AGENCY _____ NPI # _____
PHONE (_____ ) _____ - _____ FAX (_____ ) _____ - _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
DIAGNOSIS _____
Evaluate for:_____

## REQUESTING APPOINTMENT WITH/FOR

☐ Neurologist ☐ Psychoeducational 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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1311 Westbrook Plaza Drive, Suite 100 • P.O. Box 24458 • Winston-Salem, N.C. 27114-4458
(336) 659-8202 • Fax: (336) 659-8206
*Visit us at www.eiofnc.org*