



NEW PATIENT REFERRAL FORM

Date: ___ / ___ / 20___

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

NOTICE: Neurological patients will receive a **NEW PATIENT PACKET** which is to be **completed AND returned to our office** 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

Revised 2/2015