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 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 _____

REFERRING OFFICE/AGENCY

REFERRING MD/AGENCY _____
PHONE (_____) _____ - _____ FAX (_____) _____ - _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
DIAGNOSIS _____
Evaluate for:_____

REQUESTING APPOINTMENT WITH/FOR

☐ Neurologist ☐ Psychologist ☐ Therapist
☐ Neuropsychological Assessment ☐ Psychological Assessment

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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