NEUROLOGY
OF MARSHALL COUNTY

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FAX REFERRAL FORM

Referring Physician:	Referring Physician's Phone Number:
Clinic Contact:	Referring Physician's Fax Number:

Appointment Type (Please check one): _____ Consultation _____ EMG / Nerve Conduction Study

Reason for Referral: _____

Patient Information

Name:
Date of Birth:
Social Security Number:
Address:
City / State / Zip:
Primary Phone Number:
Primary Insurance:
Subscriber Name:
Subscriber Date of Birth:
Policy Number:
Secondary Insurance (if applicable)
Secondary Subscriber Name:
Secondary Subscriber Date of Birth:
Secondary Policy Number:

PLEASE INCLUDE A COPY OF PATIENT'S INSURANCE CARD(S), HISTORY AND PHYSICAL, LABS, PHYSICIANS PROGRESS NOTE(S) AND CURRENT MEDICATION LIST WITH COMPLETED REFERRAL FORM.

APPOINTMENT DATE AND TIME: _____

PATIENT NOTIFIED: _____YES _____NO

*Once the appointment is scheduled this form will be sent back to the referring physician's office. After 3 unsuccessful attempts to contact the patient we will return the referral form to the referring provider including dates/times of attempts.