Central Nebraska Neurology

AANEM Accredited Laboratory

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2021 REFERRAL FORM

PATIENT NAME _____ **DOB** _____

REASON FOR REFERRAL _____

TYPE OF REFERRAL PREFERRED

Electrodiagnostic only _____ **Full Consult** _____
If EDX only circle requested test

UPPER EXT Right Left
Lower EXT Right Left

Workman Comp Auth # _____

RECORDS REQUIRED **Place an X if included**

ALL REFERRALS
Demographic Sheet _____

Progress Note about the reason for referral _____

ALL FULL CONSULTS
Imaging (MRI, CT, ECHO, Ultrasound, Heart monitor) pertaining to reason for referral _____

Lab results from 6 months prior to referral _____

Other consultation notes regarding referral _____

Any previous Neurology notes _____

Other pertinent records

REMEMBER YOUR PATIENT WILL NOT BE CALLED TO SCHEDULE THE APPOINTMENT UNTIL WE HAVE RECEIVED THIS FORM AND THE APPROPRIATE DOCUMENTATION

Thank you for helping to provide timely and quality service for your patients