Central Nebraska
Neurology

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2020 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

We will fax confirmation of their appointment shortly after receiving your referral and records

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