REQUEST FOR APPOINTMENT
CENTRAL NEBRASKA NEUROLOGY

FAX 402-463-1461 / Phone 402-463-1250

It is preferable that the referring provider include a letter explaining the reason for the consultation and a copy of their demographic facesheet, and patient records.

The following are required prior to our office calling to make an appointment with the patient.

DATE OF REQUEST:_____

PATIENT'S NAME_____

DOB:_____ SSN:_____

ADDRESS:_____

TELEPHONE:_____

INSURANCE CARRIER_____

INSURANCE NUMBER_____

WORKMAN'S COMP: YES_____ NO_____ APPROVAL #_____
(We MUST have work comp authorization in writing from work comp company prior to scheduling)

Please circle if patient is positive for: TB HIV MRSA Hep B Hep C

REASON FOR CONSULTATION_____

EMG/NERVE CONDUCTION STUDIES ONLY (check one) YES_____ NO_____

IF YES, SELECT EXTREMITIES FOR TESTING: RUE_____ LUE_____ RLE_____ LLE_____

REFERRING PROVIDER_____

FOR CNN Office only

	Requested	In Chart	Not Done	CD Here	Date App Processed	
Recent Records						
CT (Head/Spine)						
MRI (Head/Spine)						
Lab						
Other						
Hospital Records						

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