

**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						