

Neurology (Adult & Pediatric) and Sleep Medicine
Referral Appointment Request Form

Specialty (check one): Adult Neurology Pediatric Neurology Sleep Medicine Date: _____

Please complete patient information below, or attach patient demographic information before faxing.

Patient's Name: Last _____ First _____ MI _____

DOB: _____ Male Female

Address: _____ City, ST: _____ Zip: _____

Parent/Guardian (Last, First): _____ Insured's DOB: _____

Home #: _____ Work #: _____ Cell #: _____

Language assistance needed: Patient Parent/Guardian Specify language: _____

Name of insurance: _____ ID #: _____ Insurance referral required? Yes No

Referring provider: _____ Office phone: _____

Contact name: _____ Office fax: _____

Primary care provider (if different from above): _____

Office Phone: _____ Office fax: _____

Urgency of referral (please check one):

Urgent – Please contact the Neurology office at (603) 695-2940 to discuss urgent appointment needs as follows:

For Adult: any appointments needed in less than 4 weeks from this request

For Pediatric: any appointments needed in less than 6 weeks

First Available

Reason/diagnosis: _____

Specific question to be answered: _____

Please indicate your intention of this referral by checking all boxes that apply:

Office visit: consultation only

Test only: EEG

Test only: EMG (check all that apply): Right arm Left arm Right leg Left leg
 Other (specify): _____

Before faxing this referral request to office at appointment location, please check the following information which is included so that we may complete this request.

Pertinent office notes

Patient demographics
(if separate)

Recent medication list

Insurance referral (if required)

Recent test results