Neuroscience & Rehabilitation Associates

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American Board of Neurology and Psychiatry, American Board of Clinical Neurology, American Board of Sleep Medicine

REFERRAL FORM

Patient Name	3:			D.O.B			
	First	MI	Last				
Address:				Male / Female			
City:			State:		Zi	p:	
Home #		Work #		Cell	#		
S.S. #		Insurance:		_ .		Self Pay: Yes / No	
(Please note: If cla authorization MU	aiming worker's con ST be completed pr	ior to appointment or pati	otified when ma ient will not be s	king the appointmen een.)	nt and the	e necessary paperwork and	
Referring Phys	sician:			Office Contac	ct:		
Phone:		· · · · · · · · · · · · · · · · · · ·	Fax:				
DX:							
Reason for con	ısult:		···				
Ordering:	Consult	EEG					
	_Consult & EM Circle Ext	IG/NCV remity(s): RUE LUE	BUE RLE	LLE BLE			

All of the following MUST be included before an appointment will be scheduled:

- Recent MRI/CT scan report 1.
- 2. Recent X-RAY

- Up to date medication list
 Demographic Sheet
 Dictations from office visit Dictations from office visits

Please fax this completed form to (785) 537-9486 We will call the patient to schedule an appointment. Thank you for your referral!