PHYSICIAN REFERRAL FORM

31 Dogwood Road, Asheville, NC 28806
Phone: (828) 210-9300 Fax: (828) 210-9319

Please select Physician: **[ ] First Available with any one of our Neurologists or**
[ ] James Patton, MD *(Movement Disorder Specialist)* **[ ] Matthew Engelbrecht, MD** *(Headache/Migraine Specialist)*
[ ] Robert Armstrong, MD *(Epilepsy Specialist)*

Please select service: **[ ] Consult [ ] EMG/NCV [ ] EEG**

Select Reason for Referral and Diagnosis: **[ ] Seizures [ ] Headaches/Migraines [ ] Parkinson's [ ] Tremor**
[ ] Stroke [ ] MS [ ] Brain Injury [ ] Abnormal MRI [ ] Spasticity
[ ] Muscle weakness [ ] Memory Impairment [ ] Paresthesia
[ ] Neuropathy [ ] Abnormal Gait [ ] Myasthenia Gravis [ ] Ataxia
[ ] Other: _____

Patients Name: _____ DOB: _____

Please fax the following information with this form: *(missing information may delay your patient's appointment)*
[ ] Demographic information *(Name, DOB, Address, Email, Phone numbers)*
[ ] Insurance information *(copy of current insurance cards):*
_____
(We do not accept workers comp patients)
[ ] All Evaluation notes pertaining to the specific diagnosis mentioned above
(As well as any discharge summaries from a hospital for that condition)
[ ] All imaging and testing related to the diagnosis *(including MRI, CT and EEG Reports)*
(if this has been ordered but not yet completed, please send reports to our office once completed).
[ ] All Lab work and Medications applicable to the referral
[ ] Other MD work ups on this condition that have been ruled out as cause.
[ ] Previous Neurologist: _____
[ ] Reason for Transition of Care: _____

*****The above requested documents provide our office with an initial assessment of your patient's referral to our office. We use this information to ensure that we are providing continuity of care for your patient in the most effective and efficient manner, without repeating any steps that have been addressed by you, another specialist, or facility. *****

Notes on attachments: _____

Referring Physician: _____ NPI #: _____

Name of Practice/ Facility: _____ Group NPI #: _____

Referring Physician Phone #: _____ Fax #: _____

Referral Sent by (contact name): _____ Ext.: _____

**** Please allow 24-48 hours for review; once referral has been approved we will contact the patient, caregiver or facility to schedule****