Asheville NEUROLOGY Specialists

PHYSICIAN REFERRAL FORM

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*Board Certified Neurologists

Please select service:

- ○ Evaluate and Treat
- ○ EEG Only
- ○ EMG/NCS Only
- ○ Infusion Only

Patient Info:

- Name: _____
- DOB: _____
- Best Contact # _____
- Alt. Contact # _____

Select Reason for Referral/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: _____

Please fax the following information with this form:

- Insurance Cards
- Current Medication List
- Office Note relating to reason for referral
- Imaging/Testing related to the diagnosis
- Recent or Relevant Lab Work
- Previous Neurology Records

Additional Comments: _____

**** Please allow 2-4 business days for review. Once referral has been approved, we will contact the patient, caregiver or facility to schedule****