Quality Healthcare Clinic
Community Inspired. Integrity Driven.

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2020 Referral Form

PATIENT NAME _____ **DOB** _____

REASON FOR REFERRAL _____

TYPE OF REFERRAL PREFERRED

Electrodiagnostic only _____ **Full Consult** _____
If EDX only circle required test

UPPER EXT Right Left
Lower EXT Right Left

Workman Comp Auth # _____

RECORDS REQUIRED **Place an X if included**

ALL REFERRALS
Demographic Sheet _____

Progress Note about the reason for referral _____

ALL FULL CONSULTS
Imaging (MRI, CT, ECHO, Ultrasound, Heart monitor) Pertaining to reason for referral _____

Lab results from 6 months prior to referral _____

Other consultation notes regarding the referral _____

Any previous Neurology notes _____

Other Pertinent Records _____

REMEMBER YOUR PATIENT WILL NOT BE CALLED TO SCHEDULE THE APPOINTMENT UNTIL WE HAVE RECEIVED THIS FORM AND THE APPROPRIATE DOCUMENTATION

Appointment Date_____Time_____

Thank you for helping to provide timely and quality service for your patients