PHYSICIAN REFERRAL FORM

Texas Institute for Neurological Disorders

Main Office : 321 North Highland Avenue, Suite 200, Sherman TX 75092

For Referrals: Phone: 903-891-4296 Fax: 903-328-3222 Email: referrals@texasneurologyinstitute.com

Patient Preference:

Please select Office: [ ] Denison [ ] Durant [ ] Sherman [ ] McKinney [ ] Keller
[ ] Plano [ ] Richardson [ ] Frisco [ ] Arlington

Please select service: [ ] Consult [ ] EEG [ ] Pain Procedure Evaluation
[ ] EMG/NCV **[ ] Upper** **[ ] Lower** **[ ] 1 Ext** **[ ] 2 Ext**

Reason for Referral and Diagnosis: ______________________________

Patient Information:

Patient Name: ______________________________ DOB: ______________

Address: ______________________________ City: ______________

State: ________ Zip Code: __________ Telephone # (s) ______________________________

Email Id : ______________________________

Please include the following as much as you can with this form to setup the appointment quickly.

[ ] Copy of insurance card [ ] Prior authorization # *(if applicable)* ______________

[ ] Medical Records *(include the office note referencing referral to a neurologist)*

[ ] Diagnostic test results *(include MRIs, lab work, etc. applicable to the referral)*

Referring Physician Information:

Referring Physician: ______________________________ NPI #: ______________

Name of Practice/Facility: ______________________ Group Practice NPI #: ______________

Referring Physician Phone #: ______________________ Fax: ______________

Referral Sent by *(contact name)*: ______________________ Ext: ______________

Contact email: ______________________________

(Internal use to fax back to referring physician)

Account #: ________ ***Appointment Date:*** ____________ ***Time:*** ________

Location : ***w/ Dr:*** ______________