

TIND NEUROLOGY REFERRAL

For Referrals:

Fax: 903-328-3222

Email: referrals@texasneurologyinstitute.com

Select clinic:	Arlington []	Frisco []	Plano- Coit Rd. []
	Dallas []	Grapevine []	Plano- Preston Rd. []
	Denison []	Keller []	Richardson []
	Durant []	McKinney []	Sherman []
Select service:	Consult []	EMG/NCV []	Telehealth []
	EEG []	Sleep Evaluation []	Other []

Reason for Referral and Diagnosis: _____

Patient Information

Patient Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone: _____

Patient Email: _____

Please include the following if you can with this form:

- 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 Number: _____

Name of Practice/Facility: _____

Group Practice NPI #: _____ Referring Physician Phone #: _____

Fax: _____ Referral Sent by (contact name): _____

Contact Email: _____

(Internal use to fax back to referring physician)

Account #: _____ Appointment Date: _____ Time: _____

Clinic Location: _____ Doctor: _____