www.NetworkNeurology.com

Network Neurology, LLC

Info.NetworkNeurology.com

1941 Savage Road, Suite 100-E, Charleston SC 29407
Phone 843.735.5920 Fax: 877.279.6813

Robert P. Turner, MD, MSCR

PATIENT REFERRAL FORM

NOTE: All sections must be completed fully for appointment to be scheduled.

Referral Information:

☐ Neurological Evaluation ☐ Neuromodulation Evaluation

Referral Diagnosis: _____

Reason for Referral: _____

_____

_____

Patient Information:

Patient Name (Last, First, Middle): _____ Nickname: _____

Date of Birth (mm/dd/yyyy): _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Responsible Party: _____ Relationship to Patient: _____

HOME Phone: ( ) _____ Relationship to Patient: _____

CELL Phone: ( ) _____ Relationship to Patient: _____

CELL Phone: ( ) _____ Relationship to Patient: _____

WORK Phone: ( ) _____ Relationship to Patient: _____

Other Phone: ( ) _____ Relationship to Patient: _____

Email: _____ Relationship to Patient: _____

Email: _____ Relationship to Patient: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip Code: _____

Insurance /Payment Information:

Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____

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PATIENT REFERRAL FORM

NOTE: All sections must be completed fully for appointment to be scheduled.

Provider Information:

Referring Provider: _____ NPI# _____

Office Name: _____

Office Address: _____

Phone: _____ Private Line (*Physician-Physician calls only*): _____

Fax: _____

If the patient's PCP is not the Referring Provider, **please** provide the following:

Primary Care Physician: _____ NPI# _____

Office Name: _____

Office Address: _____

Phone: _____

Fax: _____

Records being sent by your office via: ☐ Fax ☐ Mail

Records include: ☐ Medical Records ☐ Previous testing performed (MRIs, EEGs, Labs, etc.)

Referring Provider Signature: _____ Date: _____

PLEASE INCLUDE ANY PATIENT MEDICAL RECORDS RELATED TO THIS REFERRAL

Patient / Parent / Guardian will be contacted by a member of the Network Neurology staff with an appointment date and time **after** the referral and records have been received and reviewed. Thank you!