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New Patient Referral Form

Patient Information:

Patient Name:_________________________________DOB ____ /____ /_____ Gender:___________

Home Phone:_________________ Cell: _________________ Email: _______________________________

Address: ____________________________________City:______________ State: ______ Zip: ________

Primary Language: ____________________________ Interpreter Required? _____Y_____N (select one)

Emergency Contact Name: ______________________ Phone:_______________ Email: _______________

Primary Insurance: ____________________________ ID# _________________ Group #______________

Secondary Insurance: _________________________ ID# _________________ Group #______________

Attorney (if applicable): _______________________ Phone:______________ Email:_______________

Presenting Symptoms/ Diagnosis: ____

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Referring Provider Information:

Referring Provider Name: _______________________________________ NPI: ______________________

Contact: _________________________ Phone:_______________________ Fax: ______________________

Primary Care Provider:

Primary Care Provider Name: __________________________________ NPI: ______________________

Contact: ________________________ Phone: ______________________ Fax: _______________________

Please fax or email these documents, along with the completed referral form.

- Annual Wellness Visit and cognitive screening results
- Recent labs (CMP, CBC, B12, TSH, Lipid Panel, HgbA1c, RPR)
- Current medication list, problem list, and allergies
- Relevant clinical notes
- Brain MRI/CT report and images (within past year)