403 Gilead Road, Suite B
Huntersville NC, 28078
(P) 704.464.1509
(F) 704.464.1393
Email: info@ncneuro.com

REFERRAL FORM

Date: ___ / ___ / ________

Patient Name: ______________________ DOB: ____________ Phone: ______________

Referring Physician: ______________________ Referring Physician NPI: ______________

Medicaid: Practice Name and NPI: ______________________ No. of Visits: ________

Neurologic Consultation: What problem would you like us to assist with?

☐ **URGENT** ☐ **NEXT AVAILABLE**

☐ Back/Neck Pain ☐ Headaches ☐ Memory Loss/Alzheimer's ☐ Multiple Sclerosis ☐ Myopathy
☐ Neuropathy ☐ Numbness ☐ Parkinson's Disease ☐ RLS/PLMD ☐ Seizures
☐ Sleep Disturbance ☐ Sleep Apnea ☐ Stroke ☐ Tremors
☐ Weakness or low tone ☐ Developmental Delay ☐ Cerebral Palsy ☐ Tics
☐ Abnormal Head Size

Other: ____

Diagnostic Testing (EEG/EMG/NCS):

** If a diagnostic test is desired without a consultation then please check below:
☐ Diagnostic Testing ONLY (FOR SLEEP TESTING, PLEASE USE SLEEP TESTING REFERRAL FORM)

Indication For Study:
☐ Altered Mental Status ☐ Carpal Tunnel Syndrome ☐ Epilepsy ☐ Neuropathy
☐ Myopathy ☐ Peroneal Neuropathy ☐ Radiculopathy
☐ Seizure NOS ☐ Syncope ☐ Suspected Pseudoseizure ☐ Ulnar Neuropathy

Other: ____
☐ Nerve Conduction Study/EMG

☐ EEG, Routine ☐ EEG, Sleep Deprived

Ambulatory EEG ☐ 24 ☐ 48 ☐ 72 hours

Referring Physician's Signature: ______________________________

Please FAX ALL pertinent records such as insurance cards, medical records, labs, imaging reports, etc.

403 Gilead Road, Suite B / Huntersville, NC 28078 / Phone: 704-464-1509 / FAX: 704-464-1393

FOR MAPS AND DIRECTIONS: WWW.NCNEURO.COM