

HUMBOLDT NEUROLOGY FAX REFERRAL FORM

FAX NUMBER (707) 443-2847

2828 O'Neil Ln. Eureka, CA. 95503 (707) 443-9385 Ext. 100 www.humboldtneurology.com

Urgent Referral (please only use if considered truly urgent)

Referring Provider: _____ Fax: _____ Date: _____

If mid-level practitioner, **please indicate supervising physician:** _____

Person to Contact @ Referring Office: _____ Phone: _____

Primary Care Doctor (required): _____

Patient Name: _____ **DOB:** _____ **SS#** _____

Home Phone: _____ Work/Cell Phone: _____

Street: _____ City: _____ Zip: _____

If your patient is unable to make appointment for themselves, please list contact below:

Contact: _____ Relation: _____ Phone: _____

Method of Payment (All front and back of insurance card copies **must be provided**)

Primary Insurance: _____ Secondary Insurance _____

Medi-Cal ID# (If applicable): _____

*If patient is private pay, payment in full is due at the time of service.
If services require an authorization, a **hardcopy of the authorization is required.***

IF WORKER'S COMPENSATION, PLEASE FILL OUT BELOW:

Adjustor: _____ Telephone : _____ DOI: _____

Employer: _____ Claim Number: _____

Address: _____

Requested Service

Indicate Extremity

Date (For HNMG use)

Consultation

EMG

LUE RUE LLE RLE

NCV

LUE RUE LLE RLE

EEG

Please attach EEG form

EEG, Sleep-Deprived

Please attach EEG form

Diagnosis or symptoms: _____

Please send us a copy of all **pertinent** records, including recent labs, hospital visits and all MRI and/or CT's of head, neck or spine. We **require** records prior to neurologists' review and scheduling of appointments. Our physicians do review all referrals. Please **have your patients call us** one week after their referral has been sent. We will contact your office if any additional notes, tests or authorization is required. Thank you.