



# NEUROLOGY & NEUROSCIENCE ASSOCIATES, INC.

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## REFERRAL FORM

**Fax to NNA office:**      White Pond 330-572-1018      Green 330-899-0522      Medina 330-723-2709  
Wadsworth 330-723-2709      Hudson 330-342-4040      Ravenna 330-296-8208      Belden 330-494-8174

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Insurance Name (Please fax copy of card): \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Office contact: \_\_\_\_\_

Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Diagnosis or symptoms: \_\_\_\_\_

Previous testing done: \_\_\_\_\_

NNA physician requested: \_\_\_\_\_  Please assign  Stat consult requested

**If your patient requires an authorization from their insurance, please obtain and provide the following:**

Auth #: \_\_\_\_\_ # of visits: \_\_\_\_\_ Effective Dates: \_\_\_\_\_

**\*\*PLEASE FAX THE FOLLOWING DOCUMENTATION \*\***

- Copy of patient's demographic sheets
- Copy of insurance card (s)
- Most recent office notes
- Radiology reports (s) (past 5 years)
- Labs (past 6 months)
- Any other tests pertaining to the appointment

We will contact the patient, schedule the appointment, and return the following to you:

Patient is scheduled for: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician: \_\_\_\_\_

[ ] Unable to reach patient      [ ] Patient declined visit      Location: \_\_\_\_\_

Additional information needed/comments: \_\_\_\_\_

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