Referral to Humboldt Neurological Medical Group, Inc. Date: _____

Phone: (707) 443-9385 **Referral Fax: (707) 442-2362**

*****Any incomplete referrals will be refused.** ALL information below must be completed/attached in order for your referral to be complete.

☐ **Urgent Referral** ☐ **Routine Referral**

Referring Provider _____ Supervising Physician _____

Referring Office Contact _____ Phone _____ Fax _____

Patient Name _____DOB _____ Primary Care Provider _____

Mailing Address _____ City _____ State_____ Zip _____

Home Phone_____ Work/Cell Phone _____

Primary Insurance _____ Secondary Insurance _____

☐ *Completed* RAF or any other authorizations for this referral attached ☐ No authorization required

Work Comp:

Adjuster _____ Date of Injury _____ Phone _____ Claim # _____

Address _____ Employer _____

Requested Service(s):

Consultation **Sleep Consultation** **Routine EEG** **Sleep deprived EEG**

NCV-Extremities: RUE LUE RLE LLE **EMG -Extremities:** RUE LUE RLE LLE

Reason for Referral _____

Please attach: □ *Chart notes pertaining to this referral* □ *Imaging within last two years* □*Previous neurology records* □ *EEG form (if ordering EEG)* □ *Copies of current insurance cards*

PLEASE NOTE: **If the patient does not hear from us within 3 weeks, please have them call us to make their appointment at (707) 443-9385. We hold referrals for 3 months, and a new referral will need to be sent if the patient does not schedule within that window.**

☐**Refused (Incomplete Referral)** ☐**Declined** _____

☐ **Accepted** Appointment Date _____ Time _____a.m./p.m. Provider _____

7/17/2014