NEUROLOGY CONSULTANTS
HUNTSVILLE
Patient-Focused. Person-Centered.

REFERRAL FORM

Please fax patient's records *and* this completed form to:

Fax: 256-881-4105

Date: ______________________

You can type your information directly into the document.

- AMIT ARORA, M.D.
- ARUNA ARORA, M.D., M.P.H. (EMG ONLY)
- KASHA BENTON, M.D.
- KATE HEATON, M.D.
- IAN McGUINNESS, M.D.
- JAY VAN GERPEN, M.D.
- DAVID WHITE, M.D.

PATIENT INFORMATION

Patient's Name: (FIRST) ________________________ (MI) _______ (LAST) ________________________

Patient's D.O.B.: _____/_____/_____

Patient's Address: ____

____

Daytime Phone #: _________________ Cell #: _________________ Evening Phone #: _________________

PATIENT INSURANCE INFORMATION (IF NOT ATTACHED)

Primary Insurance: ____

Policy#: ______________________________________ Group#: ______________________________________

Secondary Insurance: ____

Policy#: ______________________________________ Group#: ______________________________________

Does patient's insurance require a referral? (check) Yes ____ No ____

Reason for referral/problem: ____

____

REFERRING PHYSICIAN

Physician's Name: ____ NPI#____________________________

Name of Practice: ____

Physician's Office #:______________________________ Physician's Fax #: ____________________________

First available appointment time and date will be faxed back to your office within 2 business days.

NeurologyHuntsville.com