Referral Form

Novel Clinical Research & Neurology

Referring Office Information *Items in bold are required. All else is appreciated.

Practice Name : _____

Address:_____City, State, Zip: _____

Phone: _____**Fax:** _____

Referral Coordinator/Contact: _____

Referring Provider : _____

Are you the patient's Primary Care Provider? ☐Yes ☐No.

Patient Information

Today's date: _____ **Patient's Name:** _____

Patient's DOB: _____ **Patient's Phone:** _____

Diagnosis/Reason for referral:

_____

_____

Documents Included

The following documents may assist in diagnosis, treatment, and continuity of care: (please check those you are including)

☐Last 2 office notes ☐Letter of introduction

☐Labs ☐Tests/Imaging reports

☐Current medication list ☐Medications

☐Other

What you can expect:

- We will place a call to your patient within 2 business days to arrange an appointment.
- We will contact you once the appointment has been scheduled, with the date and time.
- You will receive confirmation of the visit, office notes, and copies of all Labs and test results.
- If, for whatever reason, we are unable to reach your patient by the third call, we will contact you for further instructions.

Thank you for your referral!

We appreciate to opportunity to partner with you.