NEUROLOGY REFERRAL FORM

Attach patient facesheet, insurance card front & back, and relevant records to avoid delays
*Submit via secure fax **918-398-9214** - or HIPAA-compliant email **info@achillesneurology.com***
Thank you for your referral

REFERRING PROVIDER

Provider Name ____________________________________

NPI # ___________________

Practice / Clinic ____________________________________

Phone ___________________

Fax / Secure E-mail ___________________

PATIENT INFORMATION

Name (First MI Last) ____________________________________

Date of Birth ____ / ____ / ______

Primary Phone ___________________

Primary Email ___________________

INSURANCE *(attach copy)*

Carrier: ___________________
Member / Policy # ___________________

REASON FOR REFERRAL

Diagnosis / ICD-10: ____

Symptoms / Onset: ____

Urgency: □ Routine □ Urgent (< 2 weeks) □ Stat (< 48 hrs)

PRIOR STUDIES (✓ all completed)

□ MRI □ CT □ EEG □ EMG/NCS □ Other: ___________________

RECORDS INCLUDED (✓ all enclosed)

□ Facesheet □ Insurance Card □ Clinic/Consult Notes □ Imaging Reports / CD

□ Lab Results □ Medication List □ Other: ___________________

Referring Provider Signature: _______________________ Date: ____ / ____ / ______