RALEIGH NEUROLOGY ASSOCIATES, P.A.

PLEASE NOTE: CORRECT LOCATION

1520 Sunday Drive
Raleigh, NC 27607
919-719-8825 (Direct Line to Pediatrics)

Pediatric New Patient Appointment Triage Sheet
Please fax to: 919-788-8986
(Please include office notes, test results, & copy of Insurance card. Also send Insurance referral if required.)

ALL FIELDS REQUIRED

I request a consultation with:
Developmental Pediatrician_____
Child Neurologist_____
Physical, Occupational, Speech &/or Aquatic Therapy (Please attach an Order)_____

ASAP_____
Within 2 weeks_____
First Available_____

Patient's full name:_____

Date of Birth:_____ Age:_____ M or F (circle one)

Mailing Address - Including Zip Code:_____

_____

Contact #'s (H):_____(C):_____(W)_____

Parent's Email Address:_____

Does FAMILY Need a Spanish Interpreter? YES or NO

Referring Doctor's Name, Practice Name, Address, Phone & Fax Numbers:_____

_____

_____

Referring Group NPI#:_____

Who is calling for this appointment: _____

Parent/Guarantor Name:_____

Insurance Company Name (Specific Name):_____

Insured Party Name: _____ Insured Party's DOB:_____

Insurance ID#:_____ Group #:_____

Ins. Authorization #:_____

****IF MEDICAID, IS IT CAROLINA ACCESS? YES or NO **How Many Visits/Months?_____**

****Can authorization be used for testing also? YES or NO**

Reason for Referral-PRIMARY DX 1st 1:_____

2:_____ 3:_____

RNA Employee Initial: Today's Date & Time:_____

Appointment Date/Time/Provider Initials:_____
Notification Date:_____ to Referring Dr? to Parent? (Circle one) Initials of Notifying Staff:_____

NOTES: