RALEIGH NEUROLOGY ASSOCIATES, P.A.

Developmental Pediatrics New Patient Appointment Request/Triage Sheet

Patient's Full Name:_____

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

Parent(s) names: _____ _____

Mailing Address:_____

City: _____State:_____Zip Code:_____

Phone Numbers: (H):_____(C):_____(W)_____

Parent's Email Address:_____

Is an Interpreter needed for the family? YES or NO *Required Language:*_____

Parent/Guarantor Name:_____

Insurance Company:_____

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

Insurance ID#:_____ Group #:_____

Secondary Insurance Carrier:_____ID:_____Group:_____

If Medicaid, is it CAROLINA ACCESS? YES or NO Can authorization be used for testing also? YES or NO

Ins. Authorization/NPI#:_____ How Many Authorized Visits/Months?_____

In order to ensure the timeliest scheduling, if a patient has an HMO, Tricare, or United Healthcare Compass, or other insurance requiring a prior authorization, please complete & send any necessary documentation with the referral.

Referring Provider's Name:_____

Practice Name & Address:_____

_____

_____

Practice Phone:_____ Fax:_____

Name of Referral Coordinator requesting appointment: _____

What is the best contact number if we have a question about this referral? _____

Please indicate the reason for the referral: (circle all that apply)

Developmental Delay	*ADHD*	*School Concerns*
Autism	*Behavioral Problems*	*Other:*___

Please give a brief description of your referral concerns: _____

_____

_____

_____

Please fax this completed form along with demographics, insurance cards, and all pertinent medical and/or school records, to **919-788-8986** ***Attn: Pediatric Dev Peds New Patient Appointments***.

For Office Use Only:
Assigned Provider: _____ ☐Intake ☐ Quotient Testing ☐ Vanderbuilt ☐ SNAP Parent ☐ SNAP Teacher
☐ Pediatric Symptom Checklist ☐ Other:_____