FAX THIS COMPLETED FORM TO: 919-420-1686

RALEIGH NEUROLOGY ASSOCIATES, P.A.

1540 Sunday Drive
Raleigh NC 27607
919-782-3456
919-420-1686 (fax)

*** Please fax most recent office notes, labs, diagnostic testing, demographics and copy of insurance card along with this referral – Appointments will not be scheduled until records are received.***

Date of Referral: _____

Patient Name: _____ DOB: _____

Patient Phone: (Home): _____ (Work): _____

Address: _____

Insurance: _____ Authorization # _____

Insured ID# _____ Group# _____

Referring Physician: _____ (Phone): _____

Primary Care Physician: _____ (Phone): _____

Fax notes to: _____ Attn: _____

Reason for consult: _____

_____

_____

To be completed by RNA staff and faxed back to referring doctors office.

Appt Date, Time and Physician: _____

Referring doctor's office: Please notify patient of appointment information. Patients should check in 30 minutes prior to their appointment time and bring their insurance card, picture ID, applicable co-pay and list of current medications.