RALEIGH NEUROLOGY ASSOCIATES, P.A.

Neurodiagnostics Lab Order Form

Patient's Full Name:_____

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

Mailing Address:_____

City: _____State:_____Zip Code:_____

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

Email Address:_____

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

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

Treating Provider:_____ 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? _____

This form acts as a signed order requesting us to perform testing and/or a consult at the referring physician's request.

Reason for Referral/Evaluate For:_____

Please Select One Option Below:

_____ TESTING ONLY _____ TESTING & CONSULT _____ CONSULT ONLY

For scheduling purposes only, please estimate what might be required for this patient (check where appropriate):

	Left Arm	Right Arm	Left Leg	Right Leg
Nerve Conduction Study/EMG	_____	_____	_____	_____

Physician's Signature: _____

Please fax this completed form along with demographics, copy of insurance cards, and all pertinent medical records, including lab work and prior testing, to **919-420-6088** ***Attn: Neurodiagnostics Lab***

1540 Sunday Drive, Raleigh, North Carolina 27607 · 919-782-3456 - fax 919-420-6088 - www.RaleighNeurology.com