United Neuroscience, Inc.

9330 Stockdale Highway, Suite 200, Bakersfield, CA. 93311, United States

www.unitedneuroscience.org Phone: 661-324-0500 Fax: 661-324-0600

NEUROLOGY REFERRAL FORM

Please fax completed referral form and applicable medical records to:
United Neuroscience Institute (661) 324-0600

PATIENT INFORMATION:

☐Copy of patients' photo ID is required

☐Copies of front and back of ALL insurance cards are required

☐Please attach a current copy of the patient demographic sheet

Patient Name: _____

Date of Birth: _____ **Gender:** ☐Male ☐Female

Phone: _____ **Alternate Phone:** _____

Email: _____**Preferred Language:** _____

Reason for Referral / Diagnosis:

☐ Headache / Migraine ☐ Seizure / Epilepsy ☐ Abnormal EEG ☐ Abnormal MRI/CT
☐ Stroke / TIA ☐ Tremor / Movement Disorder ☐ Neuropathy ☐ Dizziness / Vertigo

☐ Memory / Cognitive Concerns ☐ Multiple Sclerosis ☐ Parkinson's Disease
☐ Weakness / Numbness ☐ Other: _____

Onset/Duration of Symptoms: _____

Urgency of Referral:

☐ Routine ☐ Urgent

PREFERRED SPECIALTY / PROVIDER

Please refer patient to:

☐ General Neurology ☐ Epilepsy / Seizure Specialist ☐ Neurointerventional Radiology
☐ First Available Neurology Provider
☐ Specific Provider: _____ *Patient may be scheduled with another provider in our group.

Relevant Prior Testing/Procedures:

☐ MRI ☐ CT ☐ EEG ☐ EMG/NCS ☐ Neuropsychological Testing
☐ Other: _____

ALL APPLICABLE RECORDS TO ACCOMPANY REFERRAL

☐ Recent Office Notes
☐ Recent Neurology Notes
☐ Current Medication List
☐ MRI/CT Reports
☐ MRI/CT Images
☐ EEG Report
☐ EMG/NCS Report
☐ Laboratory Results – Last 6 months
☐ Hospital/ER Records – Last 6 months

REFERRING PROVIDER

Provider Name: _____

Practice/Facility: _____

Address: _____

City/State/ZIP: _____

Phone: _____ **Fax:** _____

AUTHORIZATION

If an authorization is required a copy of the authorization must be attached to the referral. The authorization must be for location at **9330 Stockdale Hwy Ste 200, Bakersfield, CA 93311**

Authorization Required: ☐ Yes ☐ No **(Copy of Authorization must be attached)**

Authorization #: _____

INSURANCE INFORMATION: Copies of front and back of insurance cards are required

Primary Insurance: _____

Member/ID #: _____

Secondary Insurance: _____

Member/ID #: _____