

NORTHLINE NEUROLOGY

PROVIDER REFERRAL FORM | For referring offices

Complete and fax this form with supporting records to: (469) 936-7461

Please include relevant clinical records with the completed referral.

1 PATIENT & INSURANCE

Patient full name

Date of birth

Patient phone

Insurance carrier / plan name

Member ID

Group ID

Subscriber / policyholder name

Subscriber date of birth

Relationship to patient

Patient street address, city, state, ZIP

2 REFERRAL DETAILS

Clinical reason for referral / specific question to address

3 PLEASE ATTACH RELEVANT RECORDS

- | | | |
|--|--|---|
| ☐ Recent clinic notes | ☐ Current medication list | ☐ Pertinent test results |
| ☐ MRI / other imaging reports | ☐ EEG reports | ☐ Prior neurology notes |
| ☐ Hospital discharge summary (if related to a recent admission) | | |

4 REFERRING PROVIDER

Provider name and credentials

Practice / clinic

Office phone

Office fax

Referral contact / direct line

Date of referral

For clinical referrals only. Completion does not confirm appointment scheduling.