THINK
NEUROLOGY FOR KIDS

REFERRAL FORM

Thank you for choosing to refer your patients to us. To start the referral process, please fax this form to THINK Neurology For Kids.

- Fax number 281-298-1133
- Include brief pertinent medical records, including test results that support the consultation

If you require additional assistance, please call 281-298-1144.

Date: _____ From: _____

No. of Pages: _____ Title: _____

Fax: _____ Phone: _____

PATIENT INFORMATION

Name of patient: _____

DOB: _____ Interpreter needed: □ Yes □ No Language: _____

Home phone: _____ □ Work or □ cell phone: _____

Name of parent: _____

Address: _____

City: _____ Zip: _____

Insurance**: Include patient's insurance card (both sides) and HMO authorization if required**

CONSULTATION REQUEST INFORMATION

Diagnosis/ICD-10: _____

Reason for consultation: _____

_____

By providing the information requested and signing below, you agree that we may initiate treatment following consultation or perform medically necessary diagnostics, in association with this consultation. We look forward to collaboration with you on your patient's treatment plan.

REFERRING PHYSICIAN INFORMATION

Referring MD: _____ Specialty: _____

Phone: _____ Fax: _____

PCP name: _____ Phone: _____