Physicians
CHILD NEUROLOGY

New Patient Consult

Please fax this consult form with office notes, and any relevant testing results to (502)588-7852. *ALL FIELDS MUST BE COMPLETED*, or this will result in a delay in the appointment scheduling process. If you have any questions our main office line is (502)588-3650.

PATIENTS NAME:______________________ DOB:__________ SEX:____ RACE:____________

SS #:____________ PARENT/GUARDIAN:______________ PHONE#:________________

SECONDARY PHONE#:______________ PARENT/GUARDIAN NATIVE LANGUAGE:__________

FULL ADDRESS:____

PRIMARY INSURANCE:______________ SUBSCRIBER & DOB:________________

ID/GROUP#:______________________ GUARANTOR:____________________

CONSULTING DIAGNOSIS: ____

REFERRING DR: ________________ OFFICE #______________ PCP: __________

Has the Patient had any of the following (if yes tell us when/where the test was performed)

CT'S YES OR NO Location/Date:________________________________

MRI'S YES OR NO Location/Date:________________________________

EEG'S YES OR NO Location/Date:________________________________

LABS YES OR NO Location/Date:________________________________

Other YES OR NO Location/Date:________________________________

Hospital Admittance YES or NO Location:____________________________

Has the patient been seen or treated by a neurologist previously? Yes or No. If yes, when and where?

____

OFFICE CONTACT:______________ **NUMBER:**______________ **FAX:**______________

If you answered yes to any of the above questions, we *MUST* have these records before we will schedule an appointment.

Once **all records** have been received please allow 7-10 business days for the appointment to be scheduled. We will contact the office and the patient with the appointment information.

FAX NUMBER (502)588-7852