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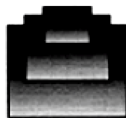

FORT WAYNE NEUROLOGICAL
center

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New Patient Referral Form

Patient Name ______________________ Date of Birth: ____________

Patient Address ______________________

City ______________ State: ____________ Zip: ________

Phone: Cell/Home: ( ) ______________ or ( ) ______________

Reason for Referral/Diagnosis: ______________________

Primary Care Physician: ______________________

Below is a checklist of information our providers need to have for them to make your patient's initial visit the most beneficial. Please review and check (√) the box if the information is available and attached to this form.

- ☐ Referring provider's office notes (last 12 months).
- ☐ Demographics, copies of Insurance card(s) & current Medication list.
- ☐ Any pertinent Labs (last 12 months).
- ☐ Insurance authorization, if insurance(s) requires.
- ☐ Previously seen by a Neurologist (last 12 months).
- ☐ Previous sleep studies if being seen for a sleep problem.
- ☐ Any testing imagery (digitally transmitted, CD or films); X-Ray, Ultrasound, EEG, EMG, EKG, Echo, CT, MRI (last 12 months).
- ☐ Any Medical Power of Attorney or Legal Guardian documentation.
- ☐ Other outside referrals / hospital (ONE, ENT, IU, Cleveland Clinic, etc.).

Provider Preference: Please check (√) for indication

FAX (50 Page Limit)	(260) 460-3130		(260) 436-9662	
	North (Parkview Campus)		West (Lutheran Campus)	
☐ No preference \ first available	☐ Madhav Bhat, MD	☐ Ajay Gupta, MD	☐ James Stevens, MD	☐ Marlene Bultemeyer, MD
	☐ Thomas Curfman, MD	☐ Fen-Lei Chang, MD	☐ Thomas Banas, MD	☐ Andrea Haller, MD

Referring Provider Information:

Provider Name: ______________________ Phone number: ____________

Contact Person: ______________________ Fax number: ____________

After successfully faxing this completed form and all available documents requested above, <u>we request that you notify your patient to call our office in 2-3 business days</u>. Once we have scheduled the appointment with the patient, we will fax this form back to your office with the confirmed date, time and neurologist.

Appointment Date and Time: ______________ A.M./P.M. with Dr. ______________

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