**Please attach all records that are related to this referral and demographics. Number of pages attached?**

|  |  |
| --- | --- |
| Practice Name: | Date: |
| Referring providers Name: | Address: |
| Referring providers NPI: | City: State: Zip:   |
| Phone: | Fax: |
| Signature: |  |

|  |  |
| --- | --- |
| Patients Name: ***0*** Male ***0*** Female ***0*** Other (specify)  | Date of Birth: |
| Primary Number: | Address: |
| Alternate Number: | City: State: Zip:   |
|  **Insurance Information:** Primary: | ID:Group: |
| Secondary: | ID:Group: |
| Work Comp or VA (require prior authorizations)   | DOI:POC: |

**Services requested**

|  |
| --- |
| Requested Provider: ***0***  David C McKee, MD ***0*** Rebecca A Meyerson, MD Services requested: EMG: ***0*** Right upper ***0***  Left upper ***0*** Bilateral upper Reason for EMG: ***0*** Right lower  ***0*** Left lower ***0*** Bilateral lower \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***0*** Consult for: DX Code:Does the patient have an upcoming surgery dependent on this referral?\_\_\_\_\_\_\_\_\_\_ Are you looking for ALS?\_\_\_\_\_\_\_\_\_\_  |