

Referral Form



**NEUROLOGY
CONSULTANTS**
HUNTSVILLE

Fax patient records *and* this completed form to:

256-429-9021

First available appointment date and time will be faxed to your office within **3 business days**.

NEUROLOGISTS

Amit Arora, M.D.

Aruna Arora, M.D. (EMG/NCS ONLY)

Kasha Benton, M.D.

Ian McGuinness, M.D.

Carolina Parker, M.D.

Jay van Gerpen, M.D.

David White, M.D.

INTERVENTIONAL NEUROLOGIST

Bhageeradh Mulpur, M.D.

Date: _____

PATIENT INFORMATION

Patient's Name: (FIRST) _____ (MI) _____ (LAST) _____

Patient's D.O.B.: ____/____/____

Patient's Address: _____

Daytime Phone #: _____ Cell #: _____ Evening Phone #: _____

PATIENT INSURANCE INFORMATION (Please fax insurance card)

Primary Insurance: _____

Policy#: _____ Group#: _____

Secondary Insurance: _____

Policy#: _____ Group#: _____

Does patient's insurance require a referral? (check) Yes _____ No _____

Reason for referral/problem: _____

REFERRING PHYSICIAN

Physician's Name: _____ NPI# _____

Name of Practice: _____

Physician's Office #: _____ Physician's Fax #: _____