NEUROTEST OF NEW YORK MEDICAL PLLC
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REFERRAL FORM

Please fax patient records and this completed form to **Fax: 872-241-0322**.
Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____

Cell Phone: _____ Email: _____

PATIENT INSURANCE INFORMATION (if not attached)

Primary Insurance: _____ Policy#: _____

Secondary Insurance: _____ Policy#: _____

Authorization# if applicable: _____

REFERRING PHYSICIAN

Physician Name: _____ NPI#: _____

Name of Practice: _____

Phone#: _____ Fax#: _____

Reason for Referral: _____

We appreciate your referral and look forward to collaborating in your patient's neurological care! We will contact your patient as soon as possible to schedule an appointment. Please provide any patient records to expedite scheduling. If your office has any further questions, please feel free to contact us at the above phone number.

For Office Use Only:

☐ Appointment made for _____
☐ Called and left voicemail but no response.
☐ Patient declined appointment.