**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?\_\_\_\_\_\_\_\_\_\_ |