



University of North Carolina
 Chapel Hill, North Carolina 27514
 Standard Clinic Referral Form

Patient Name:		DOB:	Age	UNC #
Preferred Phone #:			Other Phone #	
Interpreter Needed?: <input type="checkbox"/> Y <input type="checkbox"/> N		Language <i>other than Spanish</i> ?		
Authorization Required?: <input type="checkbox"/> Y <input type="checkbox"/> N		If Required, Authorization #:		
Insurance:		# of visits	Effective date:	
Referring Clinician:		Clinician UNC #:		Beeper #:
Referring Attending if different:			Attending UNC #:	
Referring Clinic:	Contact:	Phone #:	Fax #:	
Primary Care Provider:		UNC # or UPIN #:		
Department/Division Referring to: GENERAL NEUROLOGY			Particular Clinician: FELIX	
Chief Complaint:				
ICD-9 Code(s):		Onset Date of Signs and Symptoms:		
Reason for Referral (check appropriate box):				
<input type="checkbox"/> Consultation and Recommendations, then return to sending clinic for care. <input type="checkbox"/> Transfer of Care for this problem. <input type="checkbox"/> 2nd Opinion				

What is the specific question(s) you want addressed in this consultation?

Patient Preference for date/time of appointment: _____

Appointment date: _____ Time: _____ Clinician: _____