UNC DEPARTMENT OF NEUROSURGERY

New Patient Referral

Patient First Name	Patient Last Name	Patient Middle Name/Initial
Patient DOB:	Gender: ☐ Male ☐ Female	UNC Medical Record #:
Race:	If Pediatric patient, Name of Parent/Guardian:	
Address:		
City:	State:	Zip:
Home Tel. #:	Work #:	Cellular:
Insurance Company:		

Physician Preference and Reason for Referral

Consultation: ☐ Yes ☐ No	Transfer of Care: ☐ Yes ☐ No	2ND Opinion: ☐ Yes ☐ No
Chief Complaint & Signs and Symptoms: Date of Onset:		

Referring Physician Information

Name:	Specialty:
Practice Name:	
Address:	
UNC MD Code:	
Telephone:	Fax:
Contact Person in Office:	Telephone:
Primary Care Physician:	Telephone:

☑ ***To Expedite Appointment Fax Following Information with Referral to (919) 966-6627***

☐	Information
☐	**SURGERY** -- Operative report and pathology report
☐	**IMAGING** -- Formal reports
☐	**RADIATION/CHEMOTHERAPY** -- Treatment summary
☐	**MEDICAL THERAPY** -- Reports documenting therapy/summary
☐	**DIAGNOSTIC AND/OR THERAPEUTIC LUMBAR PUNCTURE (LP)** -- Reports/summary
☐	**LABORATORY WORK-UP** -- Lab results
☐	**OPHTHALMOLOGY WORK-UP** -- Reports/summary
☐	**OFFICE NOTES** -- Documenting findings for referral to Neurosurgery
☐	**GROWTH CHARTS (Head circumference, weight, length) ALL PATIENTS UNDER 4 YEARS OLD**

For UNC Neurosurgery use only:

Date Received:

Triaged By:

Date Patient Contacted:

Appointment Date:

Physician:

Notes: