UNC HEALTH CARE

Date of Request: _____

UNC INTERDISCIPLINARY PARKINSON'S CLINIC REFERRAL FORM

For Physicians

Please also include insurance information and all recent Parkinson's-related medical notes.

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Name: _____ UNC MR#:_____ DOB: _____

Preferred phone#: _____ Secondary phone#: _____

Insurance: _____ Authorization # (if needed): _____

NON UNC Patients ONLY

Mailing Address _____

City: _____ State: _____ Zip: _____

REFERRING CARE-PROVIDER INFORMATION:

Referring Physician: _____ UNC ID _____ UPIN _____

Clinic contact person_____ Phone # _____Fax #: _____

****SPECIFIC REFERRAL QUESTION (REQUIRED)**:**

_____

_____

Please fax the referral and all pertinent records to ATTN: JESSICA Shurer at 919-966-2922

All referrals will be seen as a consultation and recommendations will be communicated to the referring physician.