



UNC Hospitals Neurology Clinic Referral Form

Please fax back referral form and all pertinent records to (984) 974-2285. Questions? Call (984) 974-4401 or email neurologyreferrals@unchealth.unc.edu.

Please complete this form in its entirety to facilitate the consultation process. An incomplete form may result in delays.

Please note, we are currently unable to offer consultative services for low back pain, primary psychiatric disorders, chronic vertigo, TBI/PTSD or fibromyalgia. Please visit our website for more information: www.med.unc.edu/neurology.

Date of Request: _____

This form is a fillable PDF. Please **type or clearly print** your information.

PATIENT INFORMATION: Please complete the following or include demographics page.

Name _____ UNC MR# _____ DOB _____

Mailing Address _____

City _____ State _____ Zip _____

Preferred Phone _____ Secondary Phone _____

Insurance _____ Insurance ID# _____

Authorization # (if needed) _____ Authorization Dates _____

REFERRING CARE & PROVIDER INFORMATION:

Referring Physician _____ NPI _____ UNC ID _____

Clinic Contact Person _____ Phone _____ Fax _____

Facility NPI (Required) - Needed to process your referral. _____

Pertinent Medical History (Required) - Please provide details and notes. If you only write "see notes" we may inadvertently address an issue different than the one you and your patient had intended.

Onset Date of Signs / Symptoms _____

Specific Diagnosis Codes _____

Specific Referral Question (Required) - We require a question since providing only a diagnosis does not give us the clinical status information necessary to determine if there are any services our department can offer your patient.

Urgency: Is a consult needed within 48 hours? No Yes

All referrals are considered as consultations. Recommendations will be communicated to the referring physician.