TRI-STATE MOUNTAIN NEUROLOGY ASSOCIATES, P.C.

Adult Neurology

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Procedures

Electroencephalography
Nerve Conduction Studies
Electromyography
Comprehensive Epilepsy
Sleep Disorders
Polysomnography
Botox Injections
Nerve Blocks
Trigger Point Injections

PATIENT CONSULTATION FORM – REQUEST FOR SERIVCES

PATIENT NAME: _____

SOCIAL SECURITY #: _____ DOB: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE (HOME): _____ (CELL): _____

PHYSICIAN REQUESTING CONSULTATION: _____
OFFICE PHONE #: _____ FAX: _____
OFFICE CONTACT: _____

PRIMARY CARE PHYSICIAN: _____
Has patient seen a neurologist before? YES ☐ NO ☐
IF YES, NAME OF NEUROLOGISTS: _____
DATE LAST SEEN BY NEUROLOGISTS: _____

REASON FOR REFERRAL
☐ CONSULTATION: _____
☐ EMG NUMBER OF LIMBS _____
☐ ROUTINE EEG *(performed in clinic)*
☐ AMBULATORY EEG *(performed in clinic)*

Please fax the following information with this form:

- Insurance Cards
- Current Medication List
- Office note relating to the reason for referral
- Imaging/Testing related to the diagnosis
- Recent or Relevant Lab Work
- Previous Neurology Records

**** Please allow 2-4 business days for review. Once referral has been approved, we will contact the patient, caregiver or facility to schedule ****