



New Patient Referral Form

INSTRUCTIONS

Please indicate which department and physician (if you have a preference) you are referring your patient to. **Note that our office requires medical records and any studies performed such as, MRI, EMG, X-Ray, etc. should be sent along with this referral.** Documents will be reviewed by a physician at the time of the patient appointment. Tallahassee Neurological Clinic does not accept responsibility or liability for the content of such medical records until a physician-patient relationship is established during the patient's appointment visit. In the event a referring physician considers immediate review of forwarded medical records by a TNC physician to be necessary, direct physician to physician contact is required.

SELECT DEPARTMENT	SELECT PHYSICIAN	FAX REFERRAL TO
<input type="checkbox"/> Neurology	<input type="checkbox"/> Dr. Martin <input type="checkbox"/> Dr. Ayala <input type="checkbox"/> Dr. Ortiz <input type="checkbox"/> Dr. Estupinan	850-942-6515
<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Dr. Lee <input type="checkbox"/> Dr. Lawson <input type="checkbox"/> Dr. Oliver <input type="checkbox"/> Dr. Beaty	850-656-3645
<input type="checkbox"/> Pain Management	<input type="checkbox"/> Dr. Fuhrmeister <input type="checkbox"/> Dr. Lynch	850-558-1298
Appointment Requested:		
<input type="checkbox"/> New Patient Consultation		<input type="checkbox"/> EMG Study
		LT/ RT/ BIL Arm / Leg
Is visit related to an auto accident?	<input type="checkbox"/> NO <input type="checkbox"/> YES	
Is visit related to a worker's comp injury?	<input type="checkbox"/> NO <input type="checkbox"/> YES	
Has patient had an MRI and/or X-rays?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, please send report with referral

PATIENT INFORMATION

Patient Name	<input type="checkbox"/> Male	<input type="checkbox"/> Female
DOB	SSN	
Parent/Guardian (if minor)		
Address		
Email address		
Phone (Home/Work/Cell) <i>circle one</i>	Alternate Phone (Home/Work/Cell) <i>circle one</i>	
Primary Insurance Name	ID#	
Secondary Insurance Name	ID#	

REFERRING PHYSICIAN

Name of Referring Doctor:	
Phone	Fax
Primary Care Physician (<i>required</i>)	
Phone	Fax
Please indicate diagnosis/reason for visit:	
SIGNATURE OF REFERRING PHYSICIAN IS REQUIRED FOR AN APPOINTMENT TO BE MADE. PLEASE FAX ALL PERTINENT RECORDS WITH THIS REFERRAL. PLEASE NOTIFY THE PATIENT OF THIS APPOINTMENT.	
Sign:	

APPOINTMENT SCHEDULED

Appointment with Dr:		
Date	Time	am / pm