Owensboro Neurology
George Woodward, MD

T 270-691-1835 – F 270-691-1851

Neurology Patient Referral & Diagnostics Order Form

PLEASE FAX:

Demographics, Copy of Insurance Cards, Insurance Precertification for Diagnostics, & Pertinent Medical Records (Chart Note & Labs) to

270-691-1851

Patient's Full Name: _____

Date of Birth: _____ Phone Number: _____

Referring Provider Name: _____

Practice Phone: _____ Fax: _____

This form acts as a signed order requesting us to perform testing and/or a consult at the referring physician's request.

Reason for Referral/ DIAGNOSIS: _____

Please Select One Option Below:

_____ CONSULT ONLY **_____ TESTING & CONSULT** **_____ TESTING ONLY**

	Left Arm	**Right Arm**	**Left Leg**	**Right Leg**
Nerve Conduction Study/EMG	_____	_____	_____	_____

In order to ensure the timeliest scheduling, if a patient's insurance is requiring prior authorization, please complete & send any necessary documentation with the referral.

Insurance Company: _____

Precertification #: _____ Valid Dates: _____

Physician's Signature: _____

OWENSBORO
Medical Practice

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