HARTFORD NEUROLOGY LLC

Phone: (860) 522-4429
Fax: (860) 249-6742

Neurological Referral Form

Type of appointment being requested: □Consult □EMG □Consult & EMG

Please Write Patient Information:

Name _____ DOB _____ Gender o F o M

Address _____ City _____ State ____ Zip _____

Phone: Home _____ Work _____ Cell _____

Primary Insurance _____ ID _____

Secondary Insurance _____ ID _____

Workers Comp o Y o N Contact Name & Number _____

Claim / WC Authorization # _____ Date of Incident _____

Insurance Prior Authorization Required? □ Y □ N **Authorization Number:** _____

CLINICAL SUMMARY:

Body Region: □Arm □Leg Involved Site: □Right □Left □Bilateral

Chief Complaint: _____

_____

_____

Ordering Physician _____

Phone _____ **Fax** _____

PLEASE FAX FORM TO: (860) 249-6742