Precision Neurology
CENTER

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Board-Certified Neurologist

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PHYSICIAN REFERRAL TO PRECISION NEUROLOGY CENTER

Complex & Comprehensive Neurological Evaluation, Diagnosis, and Targeted Neurological Rehabilitation

1. PATIENT INFORMATION

Patient Name: _____

DOB: _____ Gender: ☐ M ☐ F ☐ Other

Phone: _____

Email: _____

MAJOR MEDICAL INSURANCE

PNC is out-of-network with major medical carriers. Insurance information is requested only for diagnostic studies ordered by Precision Neurology Center.

Insurance Company: _____

Policy #: _____ Group #: _____

MOTOR VEHICLE INSURANCE *(If applicable)*

Motor Vehicle Insurance: _____

Claim #: _____

Adjuster: _____

Adjuster Phone: _____

2. REFERRING PROVIDER INFORMATION

Referring Provider Name: _____

Clinic / Practice: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

☐ Please contact me with appointment information

Additional Contact: _____

3. PRIORITY OF APPOINTMENT

☐ Routine (Next Available)
☐ Urgent (Within 1–2 Weeks)
☐ STAT (Within 72 Hours)

Reason for Urgency: _____

4. REASON FOR REFERRAL *(Please check all that apply)*

☐ Comprehensive Neurological Evaluation
☐ Brain Injury / Concussion
☐ Motor Vehicle Collision
☐ Headache / Migraine / Pain Disorders
☐ Dizziness / Vertigo / Vestibular Disorders
☐ Balance / Gait Disorder / Falls
☐ Neuro-Ophthalmology / Oculomotor Disorders
☐ Dysautonomia / Autonomic Disorders
☐ Movement Disorders
☐ Cognitive Disorders / Memory Evaluation
☐ Neurodevelopmental Disorders
☐ Peripheral Neuropathy / Neuromuscular Disorders
☐ Neuroimmunology
☐ Neuroendocrinology
☐ Neuro-Infectious Disease
☐ Vascular Neurology
☐ Sports Neurology (Baseline Testing / Return to Play)
☐ Neuroimaging Consultation / Second Opinion
(Please request secure electronic image sharing from the imaging facility whenever available so original imaging can be reviewed.)
☐ Other: _____

5. PERTINENT RECORDS INCLUDED *(Please check all that apply)*

☐ Laboratory Reports
☐ Imaging Reports
☐ Treatment Notes
☐ Motor Vehicle Claim Information
☐ Other: _____

6. MOTOR VEHICLE ACCIDENT INFORMATION *(If applicable)*

Date of Accident (DOI): _____

Type of Collision: _____

Attorney (*If applicable*): _____

Attorney Phone: _____

Referring Provider Signature: _____ Date: _____

PLEASE FAX REFERRAL TO:
(844) 746-0040

Thank you for entrusting your patients' neurological care to Precision Neurology Center.

Precision, thoroughness, and individualized care for complex neurological conditions.