Northwest Functional Neurology
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REFERRAL FORM

ALL INFORMATION IS REQUIRED FOR THE FORM TO BE COMPLETE

Patient Name: _____DOB: _____
Address:_____
_____
Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

**Our office does not bill commercial insurance. We can provide you with a statement that includes our diagnosis codes and billed charges if you would like to submit a claim, but any reimbursement would be between you and the insurance company.

**Our office does bill motor vehicle insurance for open PIP claims. Please provide the following information if this applies to you.

Insurance Company: _____
Claim #: _____
Date of injury: _____ / _____ / _____

REFERRING PROVIDER OR FACILITY:

_____
Address:

_____

Phone: _____-_____-_____ Fax: _____-_____-_____

_____ REFERRAL FOR EVALUATION AND A COURSE OF TREATMENT
Involves the evaluation protocol described above, followed by a course of care and rehabilitation. This establishes functional care for complicated and fragile patients and creates a baseline from which the referring provider can move forward with care. A closing reevaluation and treatment plan modification is conducted prior to release back to the referring provider. Referring providers are welcome to attend and observe any or all of these visits.

_____ REFERRAL TO TRANSFER CARE