UNIVERSITY OF FLORIDA PHYSICIANS

PATIENT APPOINTMENT REQUEST FORM

FOR EXTERNAL USE ONLY

TODAY'S DATE _____

NEUROLOGY At the Shands Medical Plaza &
UF Center for Movement Disorders and Neurorestoration
Referral Phone: 352-294-5000
Fax: 352-627-4295

Consultation: ☐ General Neurology ☐ Epilepsy ☐ Memory & Cognitive Disorders
☐ Movement Disorders ☐ Neuromuscular ☐ Neurovascular

Reason for consultation: _____

☐ **If for seizures/epilepsy, convulsions, syncope or mental status changes/confusion an EEG is requested.**
Studies/ProceduresRequested _____
Level of Urgency: ◯ **Urgent** (next day) ◯ **ASAP** (within 1 wk) ◯ **Routine** (next avail.)

☐ **Transfer of Care** (Requesting referral for specialty evaluation & subsequent management of problem by the specialist alone).

Patient's Name:_____DOB:_____Medical Record #: _____
Mailing Address:_____

Home Phone: _____ Alternate Phone: _____

Please provide a copy of insurance card

Primary Insurance: _____ Secondary Insurance: _____
Address: _____ Address: _____
_____ _____
Insured's Name: _____ Insured's Name: _____
DOB: _____ DOB: _____
Policy #: _____ Policy #: _____
Phone #: _____ Phone #: _____
Fax: _____ Fax #: _____
Claim #: _____ Claim #: _____
Adjustor: _____ Adjustor: _____
Authorization #: _____ Authorization #: _____
Expires: _____ Expires: _____
Authorization good for how many visits: _____ Authorization good for how many visits: _____

You can expect to receive a report on the consult within two weeks from the consulting physician. Please retain a copy of the consultation request and the written report on the patient's condition.

Requesting Physician: _____ NPI: _____
Physician's Address: _____
Phone #: _____ Fax #: _____