Dartmouth Health

Dartmouth Hitchcock Clinic

Phone: (603) 695-2940
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Neurology (Adult & Pediatric) and Sleep Medicine

Urgency of referral (please check one):

❑ Urgent – Please contact the Neurology office at (603) 695-2940 to discuss urgent appointment needs as follows:

❑ For Adult: any appointments needed in less than 4 weeks from this request

❑ For Pediatric: any appointments needed in less than 6 weeks

❑ First Available

Reason/diagnosis: _____

_____

Specific question to be answered: _____

_____

Please indicate your intention of this referral by checking all boxes that apply:

❑ Office visit: consultation only

❑ Test only: EEG

❑ Test only: EMG (check all that apply): ❑ Right arm ❑ Left arm ❑ Right leg ❑ Left leg

❑ Other (specify): _____

Before faxing this referral request to office at appointment location, please check that the following information which is included so that we may complete this request.

❑ Pertinent office notes ❑ Patient demographics ❑ Recent medication list

❑ Insurance referral (if required) (if separate) ❑ Recent test results