NDx
NEUROLOGY
DIAGNOSTICS
Joel Vandersluis, MD

Fax Referral Form

Fax: 937-224-1770

Referring Provider's Name: _____

Referring Provider's Phone: _____

Referring Provider's Fax: _____

We invite you to join our mailing list!
Stay updated on the latest neurological services and trials available at NDx.

Email: _____

Thank you for trusting us with the care of your patient.
We strive to see all new consultations within 2 weeks.
We will notify your office when this appointment is scheduled.

Patient Information

Patient Name: _____ Date of Birth: _____
Patient Address: _____
Patient Phone: _____ Cell Phone: _____

Appointment

☐ **Consultation**

☐ **EMG/NCV**

Please Circle:
Upper Extremities Right
Lower Extremities Left

Diagnosis

- ☐ Abnormal Brain Imaging
- ☐ Alzheimer's Disease
- ☐ Confusion/Memory Loss
- ☐ Dementia
- ☐ Dizziness
- ☐ Gait Disorder/Imbalance
- ☐ Foot Drop
- ☐ Multiple Sclerosis
- ☐ Muscle Weakness
- ☐ Myasthenia Gravis
- ☐ Neuropathy
- ☐ Numbness/Paresthesia
- ☐ Parkinson's Disease
- ☐ Radiculopathy
- ☐ Seizure/Epilepsy
- ☐ Stroke
- ☐ Syncope
- ☐ Tremor
- ☐ Trigeminal Neuralgia
- ☐ Other _____

Please include patient's pertinent medical records.

Insurance Information

Primary Insurance: _____ Policy Number: _____
Secondary Insurance: _____ Policy Number: _____

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