DCND
Dayton Center for
Neurological Disorders

Referral Form

Please fax this request with all the information below to 937-439-5462.

Patient Name: _____ D.O.B _____ Please circle: Male or Female

Address: _____
(Street) (City) (Zip Code)

Home Phone: _____ Cell Phone: _____

Patient's Email Address: _____

Approved Contact Person (if not the patient/minor): _____

Does the patient need an interpreter? NO YES If yes, what type of service? _____

Primary Insurance: _____ Insurance ID: _____

Worker's Compensation: NO YES (MUST SEND APPROVED C-9 BEFORE WE CAN SCHEDULE)

HMO: NO YES If yes, Referral Number :_____(ELECTRONIC REFERRAL REQUIRED)

Referring Provider Name: _____

Physician Signature: _____

Address: _____
(Street) (City) (Zip Code)

Phone Number: _____ Fax Number: _____

Primary Care Physician: _____

Address: _____
(Street) (City) (Zip Code)

Phone Number: _____ Fax Number: _____

Urgent Request or Routine Request

Reason for appointment needed: _____

Please circle type of specialist: **Neurology** **PM&R** **EMG Test**

Special Instructions: _____

Has the patient seen a Neurologist? NO YES If yes, which physician? _____

Please include a copy of the patient's insurance card, testing, office reports, and a current medication list.
If there are any imaging discs, please have your patient bring a copy to their appointment. Once all the above information is obtained, we will call the patient to schedule within 48 business hours.

OFFICE USE ONLY

PROVIDER REFERRAL CONFIRMATION

Appointment Scheduled with: _____ Date and Time: _____

Office Location: _____

Please Circle: Unable to contact Patient does not return calls Patient declined

First Attempt: _____ Second Attempt: _____

Additional Information Needed: _____