



### New Patient Referral Form

Ferrell-Duncan Clinic Neurology - Jared Neuroscience Center  
3801 S National Avenue, Suite 900, Springfield, MO 65807  
Phone: 417-875-3087 Fax: 417-875-3088

#### REFERRING CLINIC INFORMATION

Referring Clinic Name:  
Referring Provider Name:  
Phone:

Date:  
Clinic Contact Name:  
Fax:

#### PATIENT INFORMATION

**Patients must be age 18 or older**

Patient Name: Patient Date of Birth:  
Home Address: Cell Phone:  
Home Phone:  Male  Female  Other (Specify):  
Work Phone:  Interpreter Needed:  Yes  No  
Primary Language: Contact Relationship:  
Contact Name: Policy: Group:  
1<sup>st</sup> Insurance: Policy: Group:  
2<sup>nd</sup> Insurance: Policy: Group:  
Is this a Work Comp related injury?  Yes  No  
If yes, please complete and fax referral to Work Complete at 417-269-2668  
Employer Name/Contact information:

#### REFERRAL INFORMATION

First Available Physician  Specific Physician requested (if applicable):

**Urgent appointments require a physician to physician call.**

Diagnosis/Complaint:

Chronic?  Yes  No Date of Injury/Symptoms:  
Referral type:  Consult on Condition  Assume Care of Condition  Testing Only  
 Parkinson's Clinic of the Ozarks  ALS Clinic of the Ozarks  
Neuro Related Hospitalizations:  Yes  No When/Where:  
Neuro Related ER Visits:  Yes  No When/Where:  
 Patient is on Blood Thinners If yes, RX name:  
 Patient has Pacemaker  Patient Pregnant  
Please complete ONLY if diagnostic testing is requested:

Neurodiagnostic Testing/Extremities:  NCV only  NCV/EMG  EEG only

This form must be completed and faxed with the following:

- 1) All office notes pertaining to the diagnosis/reason for referral
- 2) Any labs and diagnostic testing/imaging pertaining to the diagnosis/reason for referral (Include all reports for MRI, CT, EMG/NCV, EEG)
- 3) Patient medication list
- 4) Copy of patient's insurance card(s) including front and back and valid photo ID

**Fax this completed form to: 417-875-3088**

The patient will be scheduled as soon as possible and we will notify you of the appointment date and time.

Appointments will not be scheduled until all records are received.

#### OFFICE USE ONLY

##### Appointment Information:

Provider:  
Patient notified:  Yes  No

Date:

Time:

Staff Initials: