CAROLINA NEUROSERVICES
THE HEAD INJURY CENTER

REFERRAL FORM

Date: _____

PATIENT INFORMATION

Name _____ Phone Number _____

Address _____

Date of Birth _____ Insurance _____

Reason for Referral _____

_____

If the patient is a minor, the guardian's name: _____

IF THE PATIENT IS BEING REFERRED FOR **MEMORY PROBLEMS**, AN ADDITIONAL CONTACT IS REQUIRED:

Name of Contact _____

Relationship to Patient _____

Phone Number _____

REFERRING PROVIDER INFORMATION

Referring Provider's Name _____

Phone Number _____ Fax Number _____

Contact Person at Provider's Office _____

• Please forward any pertinent information or medical records to our office by fax at (704) 366-9931. *It is the patient's responsibility to verify mental health benefits and determine if authorization is required.*

• All patients will receive directions to our office as well as a patient registration packet for their completion.

• Please make the patient aware that we will be contacting them within 24 to 48 hours to schedule an appointment. Occasionally, we have difficulty reaching patients. If they do not receive a call within this time frame, they may call our office at (704) 366-9930. As always, we thank you for your referral.

6853 Fairview Road • Suite B • North Carolina 28210 • Telephone: 704/366-9930 • Fax: 704/366-9931