BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD, FAAN

Patient Referral Form

Thank you for the opportunity to be part of your patients' healthcare team. Please complete this form and **fax back to our office at 540-645-6623,** along with relevant office notes, diagnostic imaging, lab reports and insurance cards. Once we review the referral, we will fax appointment information back to your office. Your patient may go **online** at **SWVABRAIN.com** to fill out new patient paperwork, or they may arrive ***30 minutes early*** to their appointment to fill this out in our office.

-We are currently not accepting new patients with United Healthcare or Medicaid as primary insurance-

*****PLEASE NOTIFY YOUR PATIENT OF THE APPOINTMENT BELOW*****

REASON FOR CONSULT: _____
(do not leave blank)

Patient Name: _____ DOB: _____

Mailing Address: _____

_____

Best Contact Phone Number: _____

Physician requesting consult: _____

Name of Referring Office: _____

PCP (if NOT the referring physician): _____

Referral Contact Person: _____

FAX: _____ Phone #: _____

Insurance Company/Subscriber ID #: _____

Referral Authorization # (if required): _____

Uninsured patients: $200.00 deposit due at initial visit. Cash or Credit/Debit card only.
Any balance is due prior to further appointments.
$75.00 per return visit, due at appointment.

BRAiN Use:

*****PLEASE NOTIFY YOUR PATIENT OF THIS APPOINTMENT*****

Appt Date/Time: _____ Location: Cburg _____ Salem_____

FAXED TO REFERRING OFFICE

DATE: _____ Initials: _____

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