Neurology Partners, LLC
Referral Form
76 Park Street
Attleboro MA 02703
Ph 508.431.2026
Fax 508.431.2296

Dear Doctor;

Due to strict Medicare and Insurance guidelines, we are required by law to obtain a written request for all patients referred for Neurological Consultation or EMG.

Referral to:Dr. Kroessler:_____Dr. Callahan: _____Dr. Dhillon:_____

Patient:_____ DOB:_____

Address: _____

Phone:_____WK_____CELL_____

Insurance:_____ Number:_____

Ref. #_____Dates:_____to:_____ #Visits:_____

Primary MD:_____ Ref. Dr._____

Phone:_____ Phone:_____

Appt.Date:_____Time:_____

Work Injury?_____Auto Accident?_____

I am requesting a consult on the above patient for the following reason (s):

_____

_____

_____

Please sign:_____Date:_____

Please fax form back to ***508-431-2296***. THANK YOU.