Neurological Associates of Washington
NEUROLOGY REFERRAL FORM

PATIENT NAME: _____

DATE OF BIRTH: _____ PHONE: (_____)_____

INSURANCE: _____ (please include DEMOGRAPHIC sheet if possible)

REFERRING PHYSICIAN Clinic: _____

PHONE=: (_____)_____ FAX=: (_____)_____

___ CONSULTATION/EVALUATION ___ TESTING ONLY (SEE BELOW)

___ PLEASE CALL PT TO SCHEDULE ___ PT WILL CALL TO SCHEDULE

Please indicate your preference:

☐ Kutsy, Roman ☐ Fishel, Mark

☐ Nazor, Casey ☐ Plawner, Lauren (Pediatric) ☐ **First Available**

Please indicate below what the patient needs to be seen for:

EVALUATION FOR: **BRIEFLY DESCRIBE SYMPTOMS:**

_____ _____

_____ _____

Referral for testing only (Kirkland office) :

☐ EMG/NCV ☐ EEG ☐ MRI (order form is on our website)

_____

_____

_____

Kirkland Office:
13107 121st Way NE - Kirkland, WA 98034 ph – 425-505-3200 fax – 425-899- 6220