NEUROCARE CENTER
4105 Holiday Street, NW
PO Box 35006
Canton, OH 44735
330-494-2097 * 800-520-5695

REFERRAL REQUEST

Fax 330 – 966 – 5523

Patient's Name ____ DOB ____________________

Parent or Guardian's name (if minor) ____

Insurance ____

(Please fax a copy of both front & back of insurance card with this form)

Home Phone # ___________________________________ Work or cell # ______________________________

Home Address ____

Diagnosis ____

Degree of Urgency:

Routine ____ Urgent* ____ See within ____ days

*Referrals marked as Urgent will be seen by the first available physician within 7 – 10 days.

Do you have a physician preference? ____

(If not available, we will contact you to offer an appointment with another physician.)

For ____ Consultation ____ Routine EEG ____ EMG

____ Office visit ____ Sleep EEG ____ Upper extremity L/R/B

____ Polysomnogram ____ ENG ____ Lower extremity L/R/B

____ Carotid Ultrasound ____ Evoked potentials ____ Other (specify below)

____ Other ____

Referring physician ____

Contact person ____

Office phone number ______________________________ Office fax number ______________________________

Please fax a copy of the patient's insurance card, demographics and any pertinent Medical information including office notes and recent test results with this referral request.

Thank you for your referral. If you have any questions, please call Scheduling at 330 – 494 – 2097 ext. 0
Or 800 – 520 5695 between the hours of 8:00 am and 4:30 pm Monday through Friday.
Our fax number is 330 – 494 – 9750 and is available 24 hours per day, seven days per week.