*Attn:*________________________________ *Fax #* __________________ *Ph #* ____________________

Headache Wellness Center

1414 Yanceyville St Greensboro, NC 27405 (PH)336-574-8000 (FAX)336-574-8008

HEADACHE/MIGRAINE REFERRAL SHEET

PLEASE CONTINUE TO CALL FOR EMG/EEG REFERRALS

Patient Information		
Patient Name:		DOB:
Address:		
City:	State:	Zip
Home #	Work #	Cell #
Insurance Information – Please fax a legible copy of card. If none available, fill in information.		
Primary Insurance:		
Policy #:	Group #:	
Secondary Insurance:		
Policy #:	Group #:	
Referring Medical Practice:		
Referring Physician:		
Phone #:	Fax #:	NPI#
Address:		
City:	State:	Zip:
Contact Person:		

Please fax records regarding your treatment of this patient's headaches including MRIs and CT reports, EKG (if within last 6 months) and copy of insurance card.

Response to Referral Request

The above patient has been scheduled with Dr. Marshall C Freeman

On ___________________________ at ______________ am/pm.

Additional Information:
____
____
____

- ☐ Patient has been notified of this appointment. Instructions have been given to patient. _____
- ☐ Spoke to _________________ at __________________________. Information given. _____
- ☐ Faxed back to Referring MD on ______________________ by ___________.

**** THANK YOU FOR THIS REFERRAL ****