NY Neuromuscular Healthcare (NYN)
Phone: 607-299-4377
Fax: 607-299-4378
nyneuromuscle.com
5 Kennedy Pkwy, Cortland, NY 13045

Referral Request

Thank you for choosing NY Neuromuscular Healthcare (NYN).
We look forward to partnering with you in your patient's care.

☐ Routine
☐ Urgent

Date:_____

REFERRING PROVIDER INFORMATION:

Referred by (MD): _____
Medical Group: _____
Phone: _____ Fax: _____ PCP: _____

Address: _____ City: _____ ZIP: _____

This form completed by:_____Phone: _____

PATIENT INFORMATION (*Please provide copy of patient demographics/face sheet*):

Last Name:_____First Name:_____MI: _____
DOB:_____Phone: _____ Gender: ☐ Male ☐ Female

Patient's Address: _____
City/State/Zip:_____
Needs interpreter? ☐ Yes ☐ No Language: _____

REASON FOR REFERRAL: ***Please make sure to check for authorization or if referral is needed.***

Diagnosis/ICD:_____
Reason for the referral: _____

Type of Service Requested: ☐ Consultation ☐ NCS/EMG ☐ Autonomic Function testing ☐ Skin Biopsy
☐ Pathology Consultation ☐ Muscle Biopsy ☐ Other (please specify): _____

*__Authorization Section__: Please specify here (when **no auth.** is needed or if no **referral** is needed) which CPT codes are checked, who you spoke with and the reference number from the insurance company:

* Autonomic consultation requires abnormal autonomic testing.

DOCUMENTATION REQUIRED *(Please fax with this form)*:

- Recent/relevant typed clinical notes/test results, I.e. history & physical, NCS/EMG, EEG, MRI/CT results
- EKG results (for autonomic testing)
- Proof of insurance
- Patients Face sheet/Demographics
- Authorization information (note if required by insurance or note when on auth. is needed or referral for consult needed w/ ins.)