UAB MEDICINE
NEUROSCIENCES

## Referral Physician Information

| | | |
|---|---|---|
| Referring Physician Name | | Date (Month, DD,YYYY) |
| Practice Name | | Referring Physician Email |
| Office Address | | City |
| State | Zip Code | NPI Number |
| Phone | Fax | Primary Care Physician |

## Patient Information

| | | | |
|---|---|---|---|
| Medical Record # | Patient Name (Last, First, Middle) | | Sex<br>Male Female |
| Birth Date (Month, DD, YYYY) | Last four digits of SS # | Patient Email | |
| Address | | | City |
| State | Zip Code | | Country |
| Home Phone | Alternate Phone | Parent Name (if minor) | |
| Patient Insurance Company | | Insurance Policy # | |
| Does the patient need an interpreter?<br>Yes No | | If yes, what language? | |

## Appointment Request

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|---|
| **Clinical question to be answered. Submit any pertinent medical records.** |
| **Indication or Diagnosis** |
| This form collects information that is not part of the medical record. For local storage only.<br>Thank you for referring your patient to UAB Medicine. |

You can fax this form to 205.975.6758 or mail to: UAB Autonomic Function Testing Laboratory 1720 7th Avenue South Birmingham, AL 35233