UNC HEALTH CARE

UNC Hospitals Neurosurgery
NEW PATIENT REFERRAL FORM

Please fax back referral form and all pertinent records to (984)974-6741. Questions? Call (984)974-4175.

Date of Request: _____ *This form is a fillable PDF. Please **type or clearly print** your information.*

PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____ Middle Name/Initial _____

Date of Birth _____ Gender ☐ Male ☐ Female UNC Medical Record # _____

Race _____ If pediatric patient, name of parent/guardian _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cellular _____

Insurance Company _____

PHYSICIAN PREFERENCE AND REASON FOR REFERRAL

Consultation ☐ Yes ☐ No Transfer of Care ☐ Yes ☐ No Second Opinion ☐ Yes ☐ No Date of Onset: _____

Chief Complaint and Signs & Symptoms:

REFERRING PHYSICIAN INFORMATION

Name _____ Specialty _____

Practice Name _____ UNC MD Code _____

Address _____

Telephone _____ Fax _____

Contact person in office _____ Telephone _____

Primary Care physician _____ Telephone _____

To expedite an appointment, please fax the following information with your referral to (984) 974-6741.

- ☐ **Surgery** - Operative report and pathology report
- ☐ **Imaging** - Formal Reports
- ☐ **Radiation/Chemotherapy** - Treatment Summary
- ☐ **Diagnostic and/or Therapeutic Lumbar Puncture (LP)** - Reports/Summary
- ☐ **Laboratory Work-up** - Lab Results
- ☐ **Ophthalmology Work-up** - Reports/Summary
- ☐ **Office Notes** - Documenting findings for referral
- ☐ **Growth Charts** (Head circumference, weight, length) REQUIRED FOR ALL PATIENTS UNDER 4 years old

UNC Neurosurgery use only

Date received:

Triaged by:

Date Patient Contacted:

Appointment Date:

Physician: