UF&Shands
Neuroscience Institute
The University Of Florida Health System

REFERRAL FORM

Neurology Fax (904)244-9789
Neurosurgery Fax (904)244-9648

Today's Date: ______________ This is a: Referral _____ Pre-Authorization _____ Date Sent: ______________

Patient Name: ______________________________ SS#: ________________ DOB: ______________

Patient Home Phone: ____________________________ Patient Work Phone: ____________________

Subscriber's Name: ____

Payor/Insurance (Primary): ______________________________ ID#: ____________________

Payor/Insurance (Secondary): ____________________________ ID#: ____________________

Primary Care Physician: ________________________ Office Name: ______________________

Requesting Physician: __________________________ Office Name: ______________________

Office Phone#: ______________ Fax: ______________ Contact Name/Phone: ______________________

ICD 9 Code(s) & Descriptions: ____

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Referral #: ______________ **DOS:** ______________ **# of Visits:** ________ **Exp. Date:** ______________

THIS SECTION IS TO BE COMPLETED ONLY WHEN REQUESTING A PRE-AUTH

DOS _____ New: _____ Update _____ #of Visits _____ Total: ____ Auth # __________ Exp. Date ______________

CPT/HCPC Code(s) & Description(s): ____

____

Place of Service: Outpatient Office _____ Outpatient Surgery ____ 23 Hr Observation ______________

Inpatient Stay ________ Diagnostic Procedure _____ Home Health _____ DME _____

Received Date & Time ___________ Approved Date & Time ______________ By: ______________

THIS SECTION IS TO BE COMPLETED BY THE PROVIDER OR CLINICAL STAFF

REFERRING TO: (Complete areas that apply - Attach medical information if available)

A. Specialty Physician/Service: ______________________________ Provider ID#: ______________

Specialist Fax: ___________ Specialty: ____

B. Reason for Referral/Pre-Auth: ____

____

C. Brief History; Include Prior Authorization and Surgery: **Clinicals attached N** _____ **Y** ____ **# of pgs** _____

____

How soon does the patient need to be seen?	**Stat:**	**Appt. First Available:**	**Routine:** X

Attending Physician Signature: ______________________________ Physician ID#: ______________