

# BLUE RIDGE ASSOCIATES IN NEUROLOGY

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## Patient Referral Form

Thank you for the opportunity to be part of your patients' healthcare team. Please complete this form and **fax back to our office at 540-645-6623**, along with relevant office notes, diagnostic imaging, lab reports and **insurance card(s)**. Once we review the referral, we will fax appointment information back to your office.

Your patient may go **online** at **SWVABRAIN.com** to fill out new patient paperwork, or they may arrive **30 minutes early** to their appointment to fill this out in our office.

**-We are currently not accepting new patients with United Healthcare or Medicaid as primary insurance-**

REASON FOR CONSULT: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

Physician requesting consult: \_\_\_\_\_

Name of Referring Office: \_\_\_\_\_

PCP (If NOT the referring physician): \_\_\_\_\_

Referral Contact Person: \_\_\_\_\_

FAX: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company/Subscriber ID #: \_\_\_\_\_

**Uninsured patients: \$225.00 deposit due at initial visit. Cash or Credit/Debit card only.**

**Any balance is due prior to further appointments.**

**\$125.00 per return visit, due at appointment.**