Selkirk Neurology Clinic Referral Form

FAX this Referral Form and all ***PERTINENT*** records to (509) 795-0895
Questions? Call (509) 473-0885 or Email: info@selkirkneurology.com

All Referrals considered *Consultations*
Accepted patients are contacted by our Office to schedule
Denials will be communicated to the referring Physician/Provider to follow-up with patient

Providers should call our office with any questions.on the status of a referral
We do not consult for Spine, RLS, PTSD/TBI, chronic pain, chronic vertigo or fibromyalgia

PATIENT INFORMATION Please complete the following or include a current demographics

Name ______________________________ DOB _____________

FULL Address __________________________City ____________ State ___ Zip ____

Preferred Phone _______________ Secondary Phone _______________

Primary Insurance _________________ Insurance ID# ___________________

Secondary Insurance _______________ Insurance ID# ___________________

Authorization # (if needed) ____________Authorization Dates _________

REFERRING CARE & PROVIDER INFORMATION Please note *REQUIRED* information

Referring Physician _______________ **NPI or Facility NPI (*Required*)** ______________

Clinic Contact Person _______________Phone ______________Fax _________

Consult Relevant Medical History/RECORDS (Required) Please provide Details & Notes
If you only write "See Notes" we may deny referral based on an issue other than the one intended

Specific Diagnosis Codes ____

Onset Date of Signs/Symptoms _______________________________________

Specific Referral Question (***Required***) *Diagnosis may not provide clinical status information necessary to determine what services our clinic may offer your patient*:_____________________________
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