Referral Form

Appointment Priority: ☐ First Available ☐ This Week ☐ Within 2–3 Weeks ☐ STAT (Must Call)

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Referring Physician: _____ Phone: _____ Fax: _____

Primary Insurance: _____ HMO Y/N ____ Authorization Number: _____

PLEASE INCLUDE: PATIENT DEMOGRAPHICS, INSURANCE INFORMATION AND ALL APPLICABLE MEDICAL RECORDS TO AVOID DELAYS IN PATIENT SCHEDULING.

PLEASE FAX ALL ITEMS TO OUR PROVIDER/FAX 512-920-0142

☐ Yessar Hussain, MD

☐ Hannah Machemehl, MD

☐ Next Available Provider

REASON FOR REFERRAL

☐ Evaluation of _____

_____

_____

☐ ALS Clinic

☐ Diagnostic Testing

☐ Pathology Services

☐ Research and Clinical Trials

AUSTIN NEUROMUSCULAR CENTER

Austin Neuromuscular Center
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Austin, TX 78759
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National Neuromuscular Research Institute, PLLC

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