# REQUEST FOR CONSULTATION

Michael A. Errico, DO
Neurology/Critical Care Medicine
Phone: 912.927.6270  Fax: 912.927.6254

○ 11700 Mercy Blvd., Plaza D, Bldg. 5, Savannah, GA 31419
○ 105 Grand Central Blvd., Ste. 108, Pooler, GA 31322
○ 370 Peachtree St. Jesup, GA 31545
○ 601 E. General Stewart Way, Hinesville, GA 31313

*Please complete this form and fax it back to* ***912-927-6899****. Be sure to include the patient's medical record information, images, labs and insurance card.*

**We appreciate your referral!**

○ STAT (Physician to Physician Contact Required)   ○ Urgent (2-5 days)   ○ Routine (next available)

PATIENT INFORMATION

Name_______________________________________  Patient's Phone ( )_________________________________
Address_____________________________________  Alternate Phone (   )_______________________________
City_______________State___________Zip________  Email____________________________________________
DOB   /   /_____

PRIMARY INSURANCE
Policy Name_________________________________
Policy Holder's Name__________________________
Policy #_____________________________________

SECONDARY INSURANCE
Policy Name_________________________________
Policy Holder's Name__________________________
Policy #_____________________________________

REFERRING PHYSICIAN INFORMATION

Name_______________________________________  Referring Physician's NPI____________________
Address_____________________________________  Phone (   )_____________________________
City_______________State___________Zip________  Fax (   )______________________________
Referral Office Contact__________________________

Please answer the following:
Is this visit related to a Motor Vehicle Accident or Worker's Comp Injury?   YES   NO
Has the patient seen a Neurologist in the past?   YES   No   If yes, who? ______________________________

REASON FOR CONSULTATION

- ○ Stroke
- ○ Epilepsy
- ○ Dementia
- ○ Neuropathy
- ○ Traumatic Brain Injury
- ○ Sports Concussion
- ○ Other_________________________________
- ○ Headache/Migraines

MIGRAINES QUESTIONNAIRE
Past treatment for migraines? Yes _____   No______
Where did you get treatment? ___________________________
Physician Name: ______________________________________
What type of treatment? ______________________________
Treatment started (date) ______ Treatment ended (date) _____

*INTEROFFICE USE:*

*Date of Appt.*_________________________
*Appt. Time*__________________*AM/PM*
*Location*____________________________
*Scheduled by*_________________________
*Date Scheduled*_______________________
*MD Office Appointment Confirmed   Yes   No*
*Completed by* ________________________
*New Patient information packet mailed or patient agreed to complete online?   Yes   No*
*Completed by* ________________________