ALASKA NEUROLOGY CENTER
PROVIDING ALASKANS WITH QUALITY NEUROLOGICAL CARE

Date:____________________

Provider Referral Form

Patient Information

Last Name	First Name	Middle Initial	DOB	Age	Gender:			
					M		F	

Address	City	State	Zip	Patient Insurance #1

Home Phone	Work Phone	Cell Phone	Email	Patient Insurance #2

Medical History

Reason for Referral:

Onset Date of Symptoms		Date of Last MRI	

Provider Preference

☐	First Provider Available		
	Male Provider		Female Provider
	Specific Provider: ____________________		

Neurology Expertise Requested

	Neurology Consult		**SLEEP MEDICINE**		**INTERVENTIONAL PAIN MANAGEMENT**		**MRI IMAGING** Silent Scan Technology		* All Scans are Interpreted by Board Certified Neuro-Radilologists
	MS Evaluation		Sleep Consult *(by Board Certified Sleep Physician)*		Pain Consult		Brain		Internal Auditory Canal (IAC's)
	Seizure Evaluation		Overnight Sleep Study		Nerve Block		Orbits With Brain		Soft Tissue Neck
	TBI Evaluation		Home Sleep Study		Epidural Steroid Injection		Pituitary		TMJ
NEURODIAGNOSTICS			CPAP Supplies		Spinal Stim Trials		Brachial Plexus	**VASCULAR**	
	EMG/NCV	**NEURO-THERAPY**			Facet Injections		Metastatic Spine Survey:		Intracranial/Circle of Willis
Arm: L☐ R☐ Leg: L☐ R☐ ☐ Other ____________			Physical Therapy		Medial Nerve Block		☐ C-Spine ☐ T-Spine		☐ MRV
	EEG/EVP		Massage Therapy		SI. Joint Injection		☐ L-Spine		Carotids
WALK-IN CLINICS			Hydro Therapy		Radio Frequency Ablasion (RFA)		Reason:		Renal MRA
	Migraine		Heat Therapy		Epidural		☐ Disk ☐ MS	**MSK**	
	Traumatic Brain Injury	**INFUSION THERAPY**			Other ____________		☐ Infection ☐ Mets		Knee
	TIA/Stroke		MS Flare Up		**LUMBAR PUNCTTURE**		*History of Lumbar Surgery?		Shoulder
NEURO-PSYCH Testing			Migraine		Flouroscopy		☐ Yes ☐ No		Foot/Ankle
	Assessment & Testing		Tysabri		MS Panel		Date Mo/Yr ____________		Hip

Comments:

Referring Provider Info

Name:	Clinic:	Specialty:

Phone:	Fax:	Email:

To schedule patients, please fax completed form along with relevant chart notes, demographics, and insurance cards to 565-6001. Patients will be contacted within 24 hours.

Patient Instructions:

Your care is our upmost priority. After receiving your referral, you will be called in 24 hours to schedule the earliest available appointment.

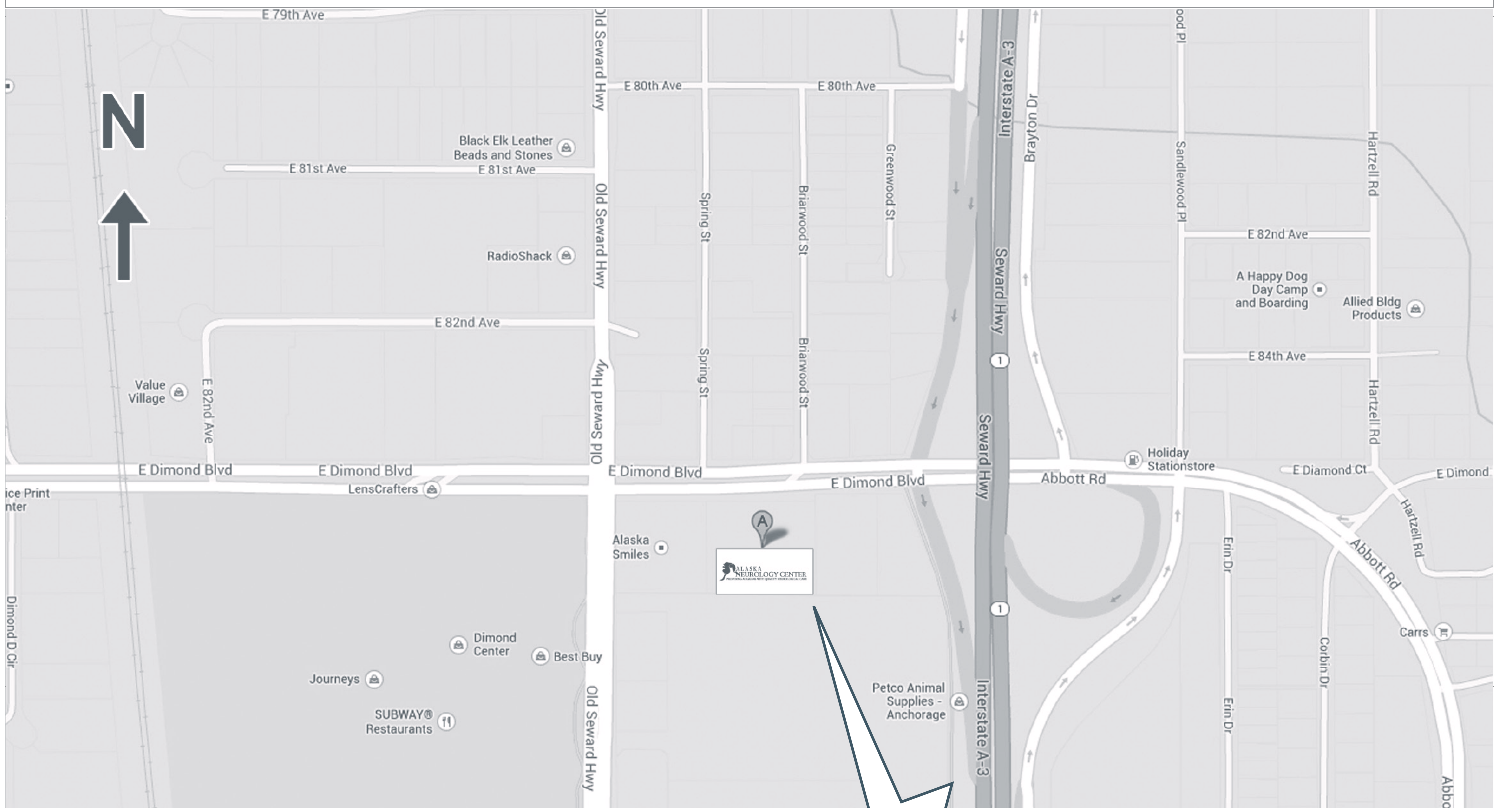
To help to expedite your care, fill out the patient paperwork provided at the time of the referral. You can fax it to 565-6001 or mail it to **AKNC 1100 East Dimond Blvd Anchorage, AK 99515.**

You also can fill out the paperwork online at www.aknc.com and email us the packet.

If you have any questions at any time please call us.

Sincerely,

Alaska Neurology Center LLC



Check list of items to bring to appointment:

	Photo ID
	Insurance Card(s)
	List of current medications (including name and dosage)
	Chart Notes/Previous Imaging CD
	List of your symptoms
	List of questions
	Notepad and pen
	Family Member (2 max please)

For scheduling, pre-registration or other inquires, please call:

565-6000 or 1-866-977-2562
Fax 565-6001 or 1-866-201-8222
1100 E Dimond Blvd.
Anchorage, AK 99515
www.aknc.com
info@aknc.com