



52 HARRISON ST 2ND FLOOR JOHNSON CITY, NEW YORK 13790

NEURO MEDICAL APPOINTMENT REQUEST

Thank you for referring your patient to our office. Please Provide the following information:

PATIENT'S NAME

ADDRESS

PHONE

WORK/CELL

GENDER

DOB

SS#

INSURANCE

ID#

 M F

REFERRED BY

PCP NAME (If NP or PA please provide supervising physician's name)

REFERRED TO OR NEXT AVAILABLE:

Aamir Rasheed, MD

Taseer Minhas, MD

Dharmesh Patel, MD

Ahmad Alwan, DO

TYPE:

General Neurology

Epilepsy

Sleep Medicine

EMG:

Unilateral/Bilateral

Uppers/Lowers

REASON FOR CONSULT

PLEASE FORWARD ANY OF THE FOLLOWING:

H&P

Bloodwork

Report Of CT, MRI, X-ray, EEG, EMGs, Etc.

Referral Form Managed Care Patients

When we receive this information, we will contact the patient for an appointment.

Thank You for your cooperation.

Neuro Medical Care Associates, PLLC