Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St, 2nd Floor Johnson City, New York 13790

RESIDENTIAL FACILITY APPOINTMENT REQUEST FORM

By Appointment Only

DATE	RESIDENTIAL FACILITY NAME	PATIENT NAME

DOB	REQUESTING PROVIDER

We have scheduled your patient for Neurologic evaluation/Neuro-diagnostic testing on _____ at _____. The following information is required prior to the patient's appointment:

- Reason for evaluation/Neuro-diagnostic testing
- Medication List
- Pertinent Medical History
- Pertinent Diagnostic Reports (Lab, Radiology, etc)

Please fax this form along with the above mentioned information at least 48 hours in advance of the scheduled appointment time. Failure to do so may result in rescheduling of the patient's appointment.

If you have any questions, please feel free to contact _____ at 607-729-1521 ext _____ .

Thank you for choosing Neuro Medical Care Associates!