# *CENTRAL ILLINOIS NEURO HEALTH SCIENCES PATIENT REFERRAL INTAKE FORM*

***1015 S. Mercer Ave., Bloomington, IL 61701 PHONE: 309-662-7500 FAX: 309-661-4877***

***Self-Referral: YES___ NO___*** ***Date:*** _____

**Patient Information**

Patient Name: _____ Email: _____
Last First MI

Home Phone (____) _____ Cell (____) _____ Work (____) _____
Best Number to Call: _____

SSN: _____ DOB: _____ SEX: _____

Address:_____

_____
City State Zip Code

**Prior Referrals**

Has patient been treated by our physicians before (even if referred by another physician): YES:_____ NO_____

If yes, which physician? _____ (Note: prior treatment may override referral preference)

**Referral Preference** **_____NO PREFERENCE**

| **Dr. Stroink** | **Dr. Nardone** | **Dr. Seibly** | ***Other Practitioners*** |
|---|---|---|---|
| **_____Bloomington** | **_____Bloomington** | **_____Bloomington** | **_____Dr. Jhee** |
| **_____Pontiac** | **_____Champaign/ Mahomet** | **_____Champaign** | |

**Chief Complaint** Has the patient had any Imaging? (MRI, CT, XRAY):___Yes ___NO
**Please Include Report**

Patient's Diagnosis for Referral: _____

Referring Physician: _____ Tel (____) _____ Referring Phy's NPI: _____
Physician's Email: _____ Cell (____) _____ Fax (____) _____

***IS PATIENT'S CONDITION URGENT?*** **If yes, why?**_____

**Patient Insurance/Workman's Compensation Information** Mailing Claims Address: _____
_____

____ Workman's Compensation ____ Private Insurance Liability Insurance: ____YES ____ NO

Company Name: _____
Group No._____ Member ID No._____

Policy Holder: _____ DOB:_____

## ***A COPY OF PATIENT'S CURRENT INSURANCE CARD(S) IS REQUIRED***

***PRE-CERTIFICATION POLICY***

***Insurance and/or workman's comp pre-certification must be conducted by the referring office and all medical reports received, prior to the patient's appointment being made by our office.***

***CINHS physicians require all patients' current records, as they pertain to this referral, prior to an appointment being scheduled. Please be sure to include all patient reports with this referral. Fax No: 309-661-4877***