AMENT HEADACHE CENTER

# Referral Form

**Referring Office Information** *Items in bold are required. All else is appreciated.

**Practice Name**: _____

Address: _____ City, State, Zip: _____

**Phone**:_____ **Fax**: _____

Referral Coordinator/Contact: _____

**Referring Provider:** _____

Are you the patient's Primary Care Provider? ☐Yes ☐No

## Patient Information

**Today's date**: _____ **Patient's Name**:_____

**Patient's DOB**: _____ **Patient's Phone**: _____

Diagnosis/Reason for referral: _____

_____

_____

## Documents Included

The following documents may assist in diagnosis, treatment, and continuity of care: (please check those you are including)

☐Last 2 office notes ☐Letter of introduction

☐Labs ☐Tests/Imaging reports

☐Current medication list ☐Medications tried for headache treatment

☐Other

Notes: _____

_____

_____

## What you can expect:

- We will place a call to your patient within 2 business days to arrange an appointment.
- We will contact you once the appointment has been scheduled, with the date and time.
- You will receive confirmation of the visit, Office notes, and copies of all Lab & Test results.
- If, for whatever reason, we are unable to reach your patient by the third call, we will contact you for further instructions.

**Thank you for your referral!**
**We appreciate the opportunity to partner with you.**