



# Neurology

Specialists of Charleston

www.NeurologyCharleston.com

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## Type of Referral:

- Evaluate /Treat    Electromyography (EMG)    Electroencephalography (EEG)    Magnetic Resonance Imaging (MRI)

Date: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Return Fax #: \_\_\_\_\_ Return Phone #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance(s): \_\_\_\_\_

Help us offer our shared patients the best and timeliest care possible. Please include the following documents in your referral:

Relevant Medical Records including labs, imaging and relevant diagnostic test

Patient Copy of Insurance Cards (front & back)

Patient Demographics

If Worker's Comp, please include adjuster information: \_\_\_\_\_

## CLINICAL INFORMATION

Reason for Referral: \_\_\_\_\_

Diagnosis / ICD: \_\_\_\_\_ Previous Neurology Workup:  YES  NO

Patient currently taking blood thinner medication?  YES  NO Medication: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Contact: \_\_\_\_\_

## PROCEDURE

EMG / NCS

BUE    RUE    LUE    BLE    RLE    LLE

Single Fiber EMG

Routine EEG    Ambulatory EEG :  24hr    48hr    72 hr

Pediatric EEG Age: \_\_\_\_\_ Responsible Party: \_\_\_\_\_

Botox Headache Therapy

Comments: \_\_\_\_\_

Neurology Specialists of Charleston wants to ensure all referring physicians are included in the status of our shared patients' treatment plans. Please let us know how you would like to be notified of this patient's appointment date and time.