CAPE FEAR VALLEY
NEUROSURGERY

(910) 615-3350

PLEASE SELECT THE PHYSICIAN YOU ARE REFERRING TO:

☐ CHARLES HAWORTH, M.D. ☐ MELISSA STAMATES, M.D. ☐ FIRST AVAILABLE

REASON FOR REFERRAL/CONSULT:______________________ DATE: __________

PATIENT INFORMATION

FULL NAME

DATE OF BIRTH (M/D/Y)

STREET ADDRESS

CITY/STATE/ZIP

HOME PHONE WORK PHONE

SOCIAL SECURITY NUMBER

HAS THIS PATIENT EVER HAD ANY NEUROLOGICAL SURGERY BEFORE?

☐ YES ☐ NO

RADIOLOGY PROCEDURES

☐ CT ☐ MRI ☐ EMG

WHEN REFERRING A PATIENT, PLEASE INCLUDE:

- Radiology Reports
- Demographics
- Recent Notes
- Physical Therapy Notes
- Procedure Reports Related to the Diagnosis
- Copies of Insurance Cards

PHYSICIAN INFORMATION

REFERRING PHYSICIAN

OFFICE PHONE FAX

PRIMARY PHYSICIAN

OFFICE PHONE FAX

REFERRING MD SIGNATURE (PLEASE DO NOT USE A STAMP) DATE

INSURANCE INFORMATION

TYPE OF INSURANCE
(IF MEDICAID, TRICARE OR VA, YOU MUST SHOW AUTHORIZATION # BELOW. IF MVA, OR WORKERS COMP., PLEASE PROVIDE ALL BILLING INFORMATION.)

AUTHORIZATION #

1ST INSURANCE POLICY # GROUP #

SUBSCRIBER NAME & DATE OF BIRTH

2ND INSURANCE POLICY # GROUP #

SUBSCRIBER NAME & DATE OF BIRTH

WE APPRECIATE YOUR REFERRAL!

WE HAVE NOTIFIED THIS PATIENT OF THE APPOINTMENT DATE AND TIME.

APPOINTMENT DATE: __________

APPOINTMENT TIME: __________

To prevent delays in scheduling your patients, please do not send multiple referral forms for the same patient.

© CFVH 9/18 • This referral form is also available at www.capefearvalley.com/referralforms.html.

Fax Completed Form to: (910) 321-6253