UAB MEDICINE
NEUROSCIENCES

Referral Physician Information

Referring Physician Name		Date (Month, DD,YYYY)
Practice Name		Referring Physician Email
Office Address		City
State	Zip Code	NPI Number
Phone	Fax	Primary Care Physician

Patient Information

Medical Record #	Patient Name (Last, First, Middle)		Sex Male Female
Birth Date (Month, DD, YYYY)	Last four digits of SS #	Patient Email	
Address			City
State	Zip Code		Country
Home Phone	Alternate Phone	Parent Name (if minor)	
Patient Insurance Company		Insurance Policy #	
Does the patient need an interpreter? Yes No		If yes, what language?	

Appointment Request

Clinical question to be answered. Submit any pertinent medical records.
Indication or Diagnosis
This form collects information that is not part of the medical record. For local storage only. Thank you for referring your patient to UAB Medicine.

You can fax this form to 205.975.6758 or mail to: UAB Autonomic Function Testing Laboratory 1720 7th Avenue South Birmingham, AL 35233