Child Neurology Consultants of Austin

CENTRAL AUSTIN CLINIC & PEDIATRIC INFUSION CENTER
7940 Shoal Creek Blvd, Suite 100
Austin, TX 78757
Phone: (512) 494-4000
Fax: (512) 494-4024

CEDAR PARK CLINIC
1301 Medical Parkway, Suite 300
Cedar Park, TX 78613
Phone: (512) 494-4000
Fax: (512) 494 4045

SOUTH AUSTIN CLINIC & PEDIATRIC INFUSION CENTER
5301 Davis Lane, Suite 200A, Building A
Austin, TX 78749
Phone: (512) 494-4000
Fax: (512) 494 4090

PATIENT REFERRAL REQUEST

Referral Date: _____ Referring Provider: _____

Patient's Name: Last _____ First _____ MI _____

Date of Birth: _____ Sex: ❑ Male ❑ Female

Address: _____ City, ST: _____ Zip: _____

Parent/Guardian Name: Last _____ First _____

Home #: _____ Work #: _____ Cell #: _____

TYPE OF REFERRAL:

Office Visit:

❑ Routine ❑ Urgent (for same day/next day appointments, please call our triage nurse)

Procedure:

❑ EEG only ICD 10 code _____

Reason/Diagnosis:

_____

_____

_____

_____

First Available ❑ Provider Preference: _____ ❑ Location Preference: _____

Please include the following information in order for us to process your referral request

- Pertinent Office Notes
- Recent Test Results
- Recent Medication List
- Patient Demographics/Face sheet (including insurance)
- Insurance Referral/Authorization Number (if required)

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