



Medical University of South Carolina
Department of Neurosciences
Division of Adult Neurology

Scheduling office: (843) 792-3223 Fax: (843) 792-2458

Thank you for the referral of your patient to MUSC Neurology. While your referral is being processed, we ask you to please complete this form and fax it along with patient office notes, labs and diagnostic studies to the number above. This will ensure that we have all of the needed information, and that your patient has been placed with the appropriate neurologist.

Patient Name: _____ DOB: _____
Address: _____ Soc Sec #: _____

Telephone #: _____ Alternate Telephone #: _____

Primary Contact: [] Patient [] Family member [] Other

* If primary contact is not patient:

Name: _____ Relationship: _____ Telephone#: _____

Secondary Contact:

Name: _____ Relationship: _____ Telephone#: _____

Insurance: _____ Insurance identification #: _____

Patient's Primary Care Physician: _____

Has the patient ever been seen at MUSC? [] yes [] no

Has a CT/PET/MRI been done? [] yes [] no

What is the reason for the referral of this patient? _____

Referring clinic: _____
Referring physician (print): _____ Signature: _____
Telephone: (____) _____ Fax: (____) _____
Address: _____

Please fax this form and include all recent office notes, diagnostic studies and lab reports
We ask for patients who have had scans, to bring a copy of the films with them

Or mail to: Adult Neurology Scheduling
96 Jonathan Lucas Street
Suite 307 CSB, PO Box 250606
Charleston, SC 29425

For patients without insurance, there is a \$50 charge at the time of the visit.
A financial counselor is available to meet with patients.