LAFAYETTE Neurology
A UNITY HEALTHCARE PARTNER

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DIRECT ACCESS FAX REFERRAL FORM

Please complete this form and fax to 765.446.5221 with the patient's last office visit note, any recent lab results, and copies of all insurance cards. We will respond to your request within 24 hours after the patient has been contacted.

Patient Name _____ ☐ Male ☐ Female DOB _____-____-_____

Address _____ SSN _____-____-_____ Contact phone _____
_____

Referring Physician _____ Phone _____ Fax _____

Insurance Company _____ ID# _____

Please check all indications for referral.

☐ Very Urgent
☐ Urgent
☐ Routine

☐ Dr. Khaled Hammoud

☐ Nerve Conduction Study / EMG of _____

☐ Headache

☐ Stroke

☐ Seizures

☐ Gait Difficulty

☐ Other:_____