



Maria A Pavez, MD

Jalil Shojaei, MD

**APPOINTMENT REQUEST FORM**

Thank you for referring your patient to Lexington Neurosciences Center! We understand that you are busy and often do not have time to spend on the phone scheduling a consultation. We have created this form to assist you with scheduling in a timely manner. Please complete the form and fax it to us at **859-255-0740**, along with the most recent clinic note and any pertinent labs. We will make every effort to contact the patient the same day, and will fax this form back to you with the date/time of the appointment for your records. Thank you very much for allowing us to participate in your patient's care!

DATE: \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

PATIENT'S ADDRESS \_\_\_\_\_

PATIENT'S PHONE NUMBER: \_\_\_\_\_ Okay to leave message?      Y    N

TYPE OF INSURANCE \_\_\_\_\_

PLEASE SCHEDULE WITH:     DR. PAVEZ                     DR. SHOJAEI                     FIRST AVAILABLE

PLEASE SCHEDULE FOR:     NEUROLOGY CONSULTATION     SLEEP CONSULTATION

EMG/NCV (TESTING ONLY)                     EMG/NCV (W/CONSULT)

Extremities \_\_\_\_\_                     EEG

REFERRING PHYSICIAN \_\_\_\_\_ CONTACT PERSON \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_ KENPAC # \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

COMMENTS/SPECIAL INSTRUCTIONS: \_\_\_\_\_

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*For LNC use:*

Patient contacted on \_\_\_\_\_ at \_\_\_\_\_ am pm.

APPOINTMENT SCHEDULED FOR \_\_\_\_\_

Referring physician notified via  phone  fax by \_\_\_\_\_

***Thank you for this referral!***