Carolina Headache Institute

REFERRAL FORM:
This form must be completed in full or treatment of the patient may be delayed
All information is strictly confidential and is intended only for the Carolina Headache Institute.

*****Please include clinic notes, demographics, insurance info (and any pertinent blood test results and radiology scans) with this referral. Otherwise, we will not be able to move forward with the process. Please see our website, www.chi09.com for more information.**

Patient Demographics:

Name: ____ DOB: ________________

Address: ____________________________________ City/State: ________________________ Zip: ____________

Primary Phone: (______)____________________ Secondary Phone: (______)____________________

Type of Insurance: _______________________________________

Referring Physician:

Name: ____

Specialty __________________________________ Practice: __________________________________

Address: ___________________________________City/State: _________________________ Zip: ____________

Phone: (______)____________________ Fax: (______)____________________

Reason For Referral: ____

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Referring to: (please circle): Next Available Dr. Kevin Kahn Dr. Alan Finkel Dr. Aurora Pajeau

Nicole Rothman, FNP

***We will try to honor your request, but ultimately our physicians will decide who is best suited to see the patient after reviewing the referral.

***Please fax this information to 919-942-4440**