



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: _____

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