Autonomic Lab Referral Form

Referring Physician Information

Referring Physician Name		Date (Month, DD, YYYY)
Practice Name		Referring Physician Email
Office Address		City
State	Zip Code	Country
Phone	Fax	Primary Care Physician

Patient Information

Medical Record #	Patient Name (Last, First, Middle)		Sex Male Female
Birth Date (Month, DD,YYYY)	Last Four Digits SSN #	Patient Email	
Address			City
State	Zip Code	Country	
Home Phone	Alternate Phone	Parent Name (if minor)	
Patient Insurance Company		Policy Number	
Does the patient need an interpreter? Yes No		If yes, what language?	

Appointment Request

Clinical question to be answered. Submit any pertinent records.
Indication or Diagnoses
This form collects information that is not part of the medical record. For local storage only. **Thank you for referring your patient to UAB Medicine.**

You can fax this form to 205-934-3896 or mail it to: UAB Autonomic Function Testing Laboratory 170 7th Avenue South, Birmingham, Al35233

Neurosciences

UAB MEDICINE