Dr. Gay B. Richardson, MD

Amanda Martin, APRN

130 Thompson-Poynter Rd
Suite 3
London, Ky 40741
Phone 606.260.8345
Fax 606.260.8352

Electrodiagnostic Referral Form

Patient Info:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Social Security Number: _____ Gender: _____ PCP: _____

Provider Info:

Provider Name: _____ NPI: _____
Practice Address: _____ Phone Number: _____
Fax Number: _____ Email Address: _____

Procedure: (please circle)

Carpal Tunnel Screening Bilateral Upper Extremities Right Upper Extremity Left Upper Extremity
Bilateral Lower Extremities Right Lower Extremity Left Lower Extremity

Diagnosis: (Please Include ICD-10 Dx Codes)

_____ _____ _____ _____

Symptoms:

_____

Length of Symptoms: _____ Months/Years

Patient Insurance:

Primary Insurance: _____
Policy Holder: _____ DOB: _____
ID Number: _____
Group Number: _____

Secondary Insurance: _____
Policy Holder: _____ DOB: _____
ID Number: _____
Group Number: _____

Referring Provider's Signature: _____ Date: _____