www.nationalbii.com
Phone #: 866-983-3167
Fax #: 1-281-942-4504
referrals@nationalbii.com

PATIENT REFERRAL FORM - can also be completed on our website

PATIENT INFORMATION (information in RED is required)

Date

Patient Name

Patient Phone #

Gender
M ☐ F ☐

Date of Birth

Commercial Policy
Yes ☐ No ☐

Firm Name & Phone #

Referring Physician Name

Referring Physician Phone #

Person Submitting Form Name & Phone #

Person Submitting Form Email

Preferred Pharmacy Name & Phone #

SERVICES REQUESTED

- ☐ Clinical Evaluation
- ☐ Life Care Plan
- ☐ Diffusion Tensor Imaging (DTI)
- ☐ Subject Matter Expert Report
- ☐ Depositions/Trial Services

REASON FOR REFERRAL

Traumatic Brain Injury (TBI) / Concussion

Symptoms/Indications (select all that apply)

- ☐ Headaches/Migraines
- ☐ Sensitivity to Light or Noise
- ☐ Memory and/or Concentration Problems
- ☐ Dizziness/Balance Problems/Ringing in Ears
- ☐ Inability to Focus/ Attention Problems
- ☐ Alteration of Speech/ Abnormal Speech
- ☐ Blurry/Double Vision
- ☐ Mental Fogginess
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Personality Changes
- ☐ Mood Swings
- ☐ Brain Bleed/Swelling
- ☐ Abnormal CT/MRI of Brain
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Sluggishness/Lethargy/ Fatigue
- ☐ Others (Specify)
- ☐ Neck Pain

Date of Injury

MECHANISM OF INJURY

- ☐ MVC
- ☐ Fall
- ☐ Industrial Accident
- ☐ Blast
- ☐ Electrocution
- ☐ Toxic Gas
- ☐ Others (Specify)

PATIENT PREFERRED LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Other

If available, please also send:

1. Clinical Notes
2. Imaging Results

Miscellaneous Notes

SELECT CLINICAL LOCATION

- ☐ San Antonio, TX
- ☐ Houston, TX
- ☐ Dallas, TX
- ☐ Telemedicine TBI Evaluation
- ☐ Los Angeles, CA
- ☐ Phoenix, AZ
- ☐ Orlando, FL

SELECT IMAGING LOCATION

Enter City & State of Preferred Imaging Location:

Fax to 1-281-942-4504 or email to referrals@nationalbii.com