Shepherd Center
ANDREW C. CARLOS MS INSTITUTE

Dear Prospective Patient:

We are pleased you are considering us as your treatment provider. This letter outlines the referral process for prospective patients. Please take a moment to review the following information.

To make a referral to the MS Institute at Shepherd Center, we must have copies of your medical records. We are unable to schedule you until we receive the following:

Currently Diagnosed with MS **(Requesting second opinion or change of provider)**	***Not* currently diagnosed with MS** **(Requesting opinion for diagnosis)**
If diagnosed within the last 5 years, we require: Office notes from the time you presented with symptoms to current treatment. Lab work/testing done to confirm MS or rule out other causes which may include: MRI (brain, spine, etc) Lumbar Puncture Results **(if previously done)** Evoked Potentials **(if previously done)** Demographics Sheet **(see following 2 pages)** **If you were diagnosed over 5 years ago, we require:** Last 5 office visit notes from your current treating neurologist Most recent MRI reports Demographics Sheet (see following 2 pages)	***Must be referred to us by neurologist or Primary Care Physician*** Office Notes Lab Reports MRI Reports Lumbar Puncture Report **(if done)** Evoked Potentials **(if done)** Demographics Sheet (see following 2 pages) (Referral may be from primary care physician, but we need records from the neurologist.)

Fax: PREFERRED METHOD
(404) 603-4517

Mail: Shepherd Center MS Institute
ATTN: MS CLINIC
2020 Peachtree Road, NW
Atlanta, GA 30309

Once your records are received, they will be reviewed by our medical provider and appropriateness of appointment will be made at that time**. Please call to insure your records were received. Once received, please allow 10 business days for your records to be reviewed/processed.**

NOTE: Do not send your MRI films or disc prior to your appointment. You MUST bring your most recent MRIs (either films or disc) with you to your appointment or the doctor will not be able to see you. Also, please do not bring disability paperwork/forms to your first appointment for us to complete. We need time to establish your care and evaluate your condition before we will be able to address your disability status.

Due to a high cancellation/no-show rate from new patients, we have recently put into place the following guidelines:

- **You must be checked-in at registration *no later* than 30 minutes prior to your designated appointment time.**
- **You are allowed ONE cancellation/reschedule for the initial appointment.**
- **If you 'no show' (do not show for appt, call to cancel less than 24 hrs prior, etc) for the initial appointment, you will not be allowed to re-schedule.**

If you have any questions, please contact New Patient Coordinator at 404-352-2020. Thank you!

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New Patient Referral Form

Demographics: Please complete the following pages of this form and send it back to us by fax, email or postal mail.

Please answer ALL questions.

Date: ______________________

Name: ____

Address: ____

____

Email Address: ____

Ok if we use email for communication? ______

Have you ever been a patient at the MS Institute at Shepherd Center in the past? __ **yes** __ **no**

Marital Status: __________ **Language:** _____________ **Race:** __________

Home Phone: ___________________ **Cell Phone:** ______________________ **Work Phone:** ____________________

Emergency Contact: ____

Name Relationship Phone #

Are you currently employed? ______ Yes ______ No

Employer Info: ____ Employed ____ Retired _____ Disabled ______ Student

Employer Name: ________________________________

If out of work due to illness, have you filed for Social Security Disability? ______ Yes ______ No

Date of Birth: ________________ **SS#:**______________________________

Specific MD or 1st Available: ________________________

Have you been diagnosed with MS? _____________ **If YES, what year?** _______________

If NO, what symptoms are you experiencing? ____

Please tell us the reason for your visit:

____

____

How did you hear about us?

- ____ **interaction with Shepherd medical provider**
- ____ **patient education program**
- ____ **other** ____

If your doctor is referring you: Doctor Name______________________ **Doctor Phone #:** __________________

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Have you had:

Diagnostic Test	Have you had this test?	Date of most recent
MRIs (brain, etc)		
Lumbar Puncture		
Evoked Potentials		

Do you physically hold a copy of your MOST RECENT MRI on film or disc? ____________________
(we are unable to schedule you if you do not have a copy of films/disc in your possession)

Primary Care Physician

Name: ____________________________________

Address: ____

City: ____________________________ State: _________ Zip Code: ______________

Neurologist

Name: ____________________________________

Address: ____

City: ____________________________ State: _________ Zip Code: ______________

Phone: ____________________________ FAX: ________________________________

(Please call your doctor's office and obtain the fax number so your records may be requested. Not providing the fax number may slow down the request.)

Insurance Information: * PLEASE INCLUDE CLEAR COPY OF YOUR INSURANCE CARDS (front & back)**

Primary Insurance

Ins. Company name:____________________ Member ID Number or Policy Number: ______________ Group Number:______________

Is this insurance purchased through the Healthcare Marketplace? ☐ *Yes* ☐ *NO*

We are not in network with all plans. We need to determine if we are in network with your particular plan.

Address: ______________________________________

Phone Number for verification of Benefits: ___________________

Insured's Name: ______________________ DOB:_____________ SS#:____________________

Secondary Insurance:

Ins. Company name:____________________ Policy: ______________Group:______________

Address: ______________________________________

Phone Number for verification of Benefits: ___________________

Insured's Name: ______________________ DOB:_____________ SS#:____________________