MEMORIAL HERMANN
Mischer Neuroscience Associates

Current Neurology Clinic (CNS)
Patient Referral

REFERRAL TO: (Recipient)	
Name:	Specialty:
Phone:	
FROM: (Referring Provider)	
Today's Date:	
Referrers Name:	
Referrers NPI:	Specialty: Neurology
Office Contact (other than MD):	
Office Address: 10905 Memorial Hermann Dr. Ste 111, Pearland, Texas 77584	
Office Phone: 281-929-4727 Office Fax: 281-929-4728	
Email Address: currentneurologysolutions@memorialhermann.org	
PATIENT DETAILS	
Patient Name:	
Date of Birth:	Medical Record Number (MRN):
Phone Number:	Email Address:
Primary Care Physician:	
REASON FOR THE REFERRAL	
Diagnosis:	
Referring Provider Remarks:	

☐ I, referring provider, attest that I have discussed this referral with the patient, and the patient has provided consent to the sharing of their demographic and contact information with Memorial Hermann or its affiliated providers for the purposes related to this referral, including: (1) telephone calls and text messages regarding health care, including but not limited to scheduling, reminders, and medication refills; (2) email or mail communications regarding health care, including but not limited to scheduling, reminders, and medication referrals; and (3) other information regarding my health care, billing and health related services and benefits. I have instructed the patient if they wish to revoke this consent, they may contact Memorial Hermann at 713-222-CARE (2273) or opt out directly after receipt of communication.

_____	_____	_____	_____	☐ AM ☐ PM _____	_____
Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**