



**Duke ALS Clinic**  
932 Morreene Road, Durham, NC 27705  
Phone: 919-668-2875 Fax: 919-668-2901

**Richard S. Bedlack, MD, Ph.D**

**ALS & Motor Neuron Disease Evaluation**

**REFERRAL FORM**

Patient's Full Name \_\_\_\_\_ DOB \_\_\_\_\_

SS # \_\_\_\_\_ Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Family Member: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer: \_\_\_\_\_

Referring Physician Name \_\_\_\_\_ Date of Referral \_\_\_\_\_

Practice Name \_\_\_\_\_

Office # \_\_\_\_\_ Fax # \_\_\_\_\_

Office Contact Person(s) \_\_\_\_\_

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Employer: \_\_\_\_\_

Please include **Medical Records** (office notes, MRI scans of head, neck, spine, lab work, EMG and/or Nerve Conduction Studies, etc.).

Referral and records to be faxed to **919-668-2901, ATTENTION: Stacey Asnani, MSW, LCSW**  
**Duke ALS Clinic Coordinator**

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(For office use only) IDX:  YES  NO MRN: \_\_\_\_\_

Date Referral Received \_\_\_\_\_ Date Medical Records Received: \_\_\_\_\_

Appointment Date & Time \_\_\_\_\_ EMG:  Yes: \_\_\_\_\_  No

Name of person notified of patient appointment \_\_\_\_\_  Letter  
 Appt. sheet

Notes: \_\_\_\_\_

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