

**FAX REFERRAL FORM DR. ERIC BECK, MD**

VALLEY CENTER FOR  
**Nerve Studies & Rehabilitation**  
**ERIC R. BECK, MD, PHD, FAAPMR**  
*Experienced, personalized care for effective results*

Fax to 256-382-1607. We will call patient to schedule their appointment.  
 Form also available at www.ericbeckmd.com.

Referring Physician/Source \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Email \_\_\_\_\_

How do you prefer to receive your reports?  Fax  Mail  Both

**PATIENT**

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_

Insurance \_\_\_\_\_

Policy No. \_\_\_\_\_

**REASON FOR REFERRAL**

**Nerve Testing (EMG/NCV)** Upper Extremity R \_\_\_ L \_\_\_ Both \_\_\_  
 Lower Extremity R \_\_\_ L \_\_\_ Both \_\_\_

Diagnosis \_\_\_\_\_

**Evaluation and Treatment**

Diagnosis \_\_\_\_\_

**Other** \_\_\_\_\_

**Workers Compensation**

Claim # \_\_\_\_\_

Case Manager \_\_\_\_\_

Address \_\_\_\_\_

Adjustor \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

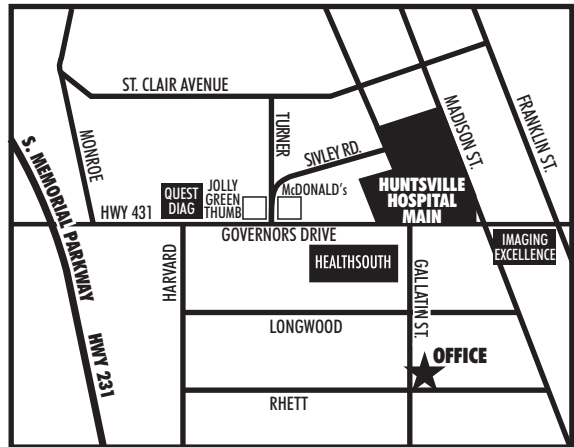
Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Check preferred method to receive reports  Fax  Mail

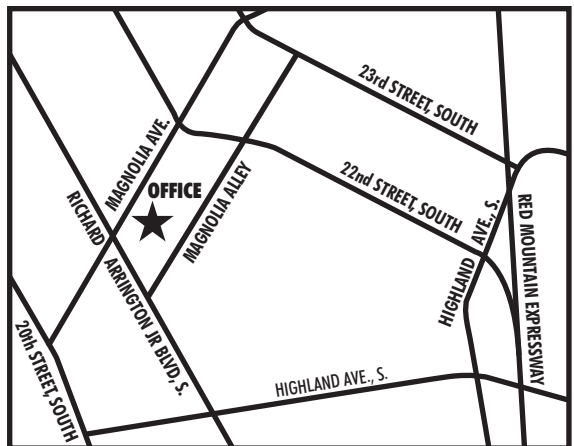
Employer \_\_\_\_\_ DOI \_\_\_\_\_

**PREFERRED OFFICE (Please check)**



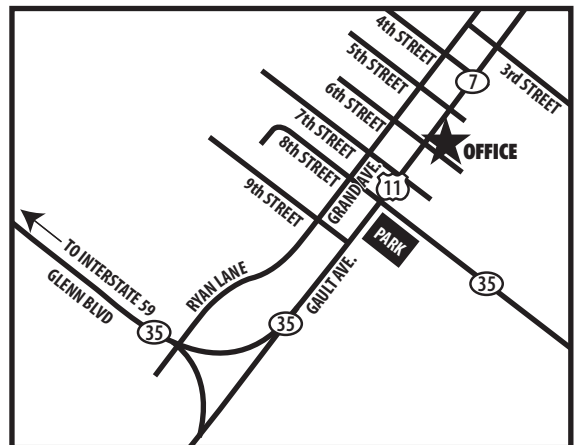
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