

Kootenai Health Neurodiagnostic Department Referral Form

~~Instructions: Please fax this referral form with a current ICD and a demographics page to~~

us at **208-769-8571**. (If for a pediatric patient, please include complete guarantor information).
Once we have received all the patient information we will contact the patient directly to
schedule. If you need to schedule directly with us, or have questions, please call us at 208-
625-6805.

Patient Name: _____ DOB: _____ Age: _____

Contact Phone: _____ Alternate Phone: _____

~~Name of person(s) and phone number(s) to contact if other than patient or if patient is a~~