PHIL SMITH ALS AND MOTOR NEURON DISEASE CLINIC REFERRAL FORM

Phil Smith Neuroscience Institute at Holy Cross Health
1931 NE 47th Street
Fort Lauderdale, FL 33308

Patient's Name: _____ Date of birth: _____

Address (Street, City, State, Zip): _____

Best phone contact (home, cell): _____

Email: _____

Employer: _____

Spouse/Family/Caregiver Name: _____

Referring Provider (if applicable): _____

Referring Provider Contact: _____

Insurance information (attach photo of cards and license): _____
_____

Fax or email medical records including office notes, MRI, EMG, and lab work to:

ATTN: Fiona Scarlett, RN, ALS Clinic
PHONE: 954-542-3436
FAX: 954-414-9751
EMAIL: ALSclinic@holy-cross.com

ALS ASSOCIATION
CERTIFIED TREATMENT CENTER OF EXCELLENCE