



Little Buddies Child Neurology, PLLC  
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## Referral Form

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Primary phone number: \_\_\_\_\_ Alternative phone number: \_\_\_\_\_

Insurance (please include a copy of the front and back of the card): \_\_\_\_\_

This is a request for (please select one):

- New patient referral
- EMG and nerve conduction studies with consultation (study report and consultation note with clinical correlation sent back to the referring physician; Dr. Snyder will follow the patient if necessary)
- EMG and nerve conduction studies only (only study report sent back to the referring physician)
- EEG only (only study report sent back to the referring physician)

Reason for the referral/specific question for Dr. Snyder's: \_\_\_\_\_

List all prior work up (including EEG, MRI, EMG, LP, etc.): \_\_\_\_\_

List all prior treatment interventions (including dosing, reasons for failure and adverse reactions): \_\_\_\_\_

Referring physician (please print): \_\_\_\_\_

Referring physician's address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Primary care physician (if different; please print): \_\_\_\_\_

Primary care physician's address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Please, fax this completed form along with patient demographic sheet, insurance card copy, medical records (including from previous neurologists'), labs, EEG, imaging studies results, growth charts etc.  
Thank you.

Appointment date: \_\_\_\_\_ Time: \_\_\_\_\_