QUEEN'S NEUROSCIENCE INSTITUTE

QUEEN'S UNIVERSITY MEDICAL GROUP

REFERRAL FORM

Thank you for entrusting Queen's Neuroscience Institute with your patient's care.
Please complete this form and fax to the appropriate location.
Appointments will not be scheduled until all pertinent records are received.

☐ **Parkinson's and Movement Disorders Center:** Phone: 808-691-4577 • Fax: 808-691-8865
Michiko Bruno, Fay Gao

☐ **Brain and Memory Center:** Phone: 808-691-2540 • Fax: 808-691-8865
Abraham Chyung, Karen DaSilva, Tracie Umaki

☐ **Queen's Neurology:** Phone: 808-691-8866 • Fax: 808-691-8865
Alexandra Galati, Linda Jaffe, Karen Morgenshtern Yacoby, Serena Thompson

☐ **Queen's Neurosurgery:** Phone: 808-691-2727 • Fax 808-691-4127
David Dadey, Daniel Donovan, Michon Morita, Yi Zhang

☐ **Queen's Neurointerventional Surgery:** Phone: 808-691-2727 • Fax: 808-691-4127
Ferdinand Hui, Samuel Tsappidi, Yi Zhang

Patient Information

Patient Name: _____ **Gender:** ☐ Male ☐ Female **Is the patient pregnant?** ☐ Yes ☐ No

Date of Birth: _____ **MRN/SSN:** _____

Home Phone: _____ **Work Phone:** _____ **Mobile:** _____

Preferred Language: _____

Primary Insurance: _____ **Authorization #:** _____

Secondary Insurance: _____ **Authorization #:** _____

Referral Information

REQUESTED SUBSPECIALTY: ☐ General ☐ CNS Autoimmune/Multiple Sclerosis ☐ Cognitive/Behavioral/Dementia
☐ Electromyography/Nerve Conduction Study (EMG/NCS) ☐ Epilepsy ☐ Headache ☐ Movement/Parkinson's
☐ Neuromuscular/ALS/MG ☐ Neuropsychology Testing ☐ Stroke

Requested Provider (if known): _____

Diagnosis and Associated ICD-10 Code(s): _____

Do any of the following conditions apply (select all that apply)? _____

CNS Autoimmune/Multiple Sclerosis:
☐ Flare up of symptoms ☐ Hospital follow-up ☐ Need discussion of disease modifying agent ☐ Newly diagnosed MS
☐ Referral from another neurologist ☐ Transfer of care from another neurologist

Cognitive/Behavioral/Dementia:
☐ Patient has an established diagnosis of dementia
☐ Patient has a suspected diagnosis of dementia. If the patient has a suspected diagnosis of dementia, has the patient received the following blood tests within the last year? If not, please submit a blood test: ☐ CBC ☐ CMP
☐ TSH with reflex ☐ Vitamin B12 ☐ MMA ☐ Folate ☐ RPR ☐ None

Referral Information (Continued)

Electromyography/Nerve Conduction Study (EMG/NCS):

☐ Referral or transfer of care from neurology, neurosurgery, or orthopedic surgery

Epilepsy:

☐ Complicated epilepsy failing 2 antiepileptic drugs
☐ History of status of epilepticus
☐ Hospitalized for confusional episode without diagnostic data to support seizure specific confusional episode
☐ Hospitalized for multiple neurological problems
☐ Referral for epilepsy monitoring unit admission
☐ Referral for epilepsy surgery
☐ Referral for management of implanted device for epilepsy (VNS, RNS, temporal lobectomy, DBS)
☐ Referred by another neurologist

Headache:

☐ Idiopathic Intracranial Hypertension (IIH)
☐ Referral or transfer of care from another neurologist
☐ Referral for nerve block

Movement/Parkinson's:

☐ Consideration of DBS surgery
☐ Referral from another neurologist
☐ Request for focused ultrasound
☐ Transfer of care from another neurologist
☐ Management of DBS
☐ Request for botulinum toxin injection for blepharospasm, cervical dystonia, or spasticity

Neuromuscular/ALS/MG:

☐ Hospital follow-up
☐ Patient has a positive acetylcholine antibody, fasciculation and/or atrophy in muscle, or abnormality in EMG/CNS test
☐ Referral for EMG/NCS *(PLEASE COMPLETE THE EMG ORDER FORM)*
☐ Referral from another neurologist
☐ Transfer of care from another neurologist

Neuropsychology Testing:

• Has the patient been seen by a specialist before? ☐ Concussion specialist ☐ Neurologist ☐ No
• If the patient was seen by a neurologist, has the patient had a MOCA or MMSE or other cognitive screener? ☐ Yes ☐ No
• What is the reason for the test? ☐ Characterizing cognitive function ☐ Complicated headaches ☐ Epilepsy
☐ Evaluation for DBS placement ☐ Functional capacity for employment ☐ Multiple sclerosis ☐ Parkinson's disease
☐ Stroke ☐ Suspected cognitive decline (Alzheimer's, dementia) ☐ Traumatic brain injury ☐ No/other: _____

Stroke:

☐ Aneurysm management ☐ Hospital follow-up seen by a neurologist ☐ Other diagnosis in addition to stroke
☐ PFO or Watchman evaluation ☐ Pre-procedure clearance ☐ Referral from another neurologist

FAX THIS FORM WITH COPIES BELOW (AS APPLICABLE)

☐ Demographic sheet/ID/Insurance
☐ Pertinent imaging reports and DISCs (MRI, MRA, CT, CTA, etc.)
☐ Insurance pre-certification/authorization
☐ Last (2) neurology/neurosurgery notes
☐ Last (2) office visit notes
☐ Other pertinent records (EEG, EMG, lab results, neuro psychology notes, physical therapy notes, etc.)

Referring Physician (Print): _____ **Phone:** _____ **Fax:** _____ **Date:** _____

Primary Care Physician Name: _____ **Date:** _____

EMG/NCS ORDER FORM

Queen's Neuroscience Institute Outpatient Center • Physicians Office Building 3 • Phone: 808-691-8866

Patient Name: _____ **Date of Birth:** _____

*If you order an EMG and Nerve Conduction Study test without a referral/consult, you are responsible for reviewing the results with the patient.

1. **Do you know what EMG/NCS test to order?**
   ☐ Yes - Please continue questionnaire
   ☐ No - Please do not submit EMG/NCS form and only order a Referral to Neuroscience. A neurologist can evaluate the patient and determine the appropriate test.
2. **Patient's symptoms:** ☐ Numbness ☐ Paresthesia ☐ Weakness ☐ Pain ☐ Other_____
3. **Where are the symptoms?** ☐ RUE ☐ LUE ☐ RLE ☐ LLE ☐ Right face ☐ Left face ☐ Generalized
   ☐ Other_____
4. **Working diagnosis:** ☐ Carpal Tunnel Syndrome ☐ Ulnar Mononeuropathy ☐ Peripheral Polyneuropathy ☐ Cervical Radiculopathy ☐ Lumbosacral Radiculopathy ☐ Myopathy ☐ Motor Neuro Disease/ALS ☐ Guillain-Barre Syndrome ☐ CIDP ☐ Myasthenia Gravis ☐ Phrenic Neuropathy ☐ Critical Illness Neuropathy ☐ Critical Illness Myopathy
   ☐ Brachial Plexopathy ☐ Other_____
5. **Is the patient on a blood thinner?** ☐ No ☐ If YES, please check:
   ☐ Aspirin ☐ Clopidogrel/Plavix ☐ Warfarin/Coumadin ☐ Dabigatran/Pradaxa ☐ Apixaban/Eliquis ☐ Rivaroxaban/Xarelto ☐ Enoxaparin/Lovenox ☐ Fondaparinux/Atrixtra ☐ Other_____
6. **Is the patient on Mestinon (Pyridostigmine)?** ☐ No ☐ Yes: Pyridostigmine should be held on the day of the exam.
7. **Does the patient have a pacemaker or other implanted stimulator?** ☐ No ☐ Yes
8. **Does the patient have a central line or PICC line?** ☐ No ☐ Yes
9. **Has patient ever had botulinum toxin injections?** ☐ No ☐ Yes
10. **Has the patient ever had spine surgery?** ☐ No ☐ If YES, please check: ☐ Cervical ☐ Thoracic ☐ Lumbosacral
11. **Special instructions for the electromyographer:** _____

EMG/NCS process instructions:
Complete the above and fax to 808-691-8865 along with insurance information, demographics, office notes and relevant diagnostic testing.
At the time of the EMG/NCS appointment, the patient's skin should be clean without any lotions, oils or creams. If the patient is on mestinon (pyridostigmine), they should not take it the day of the test.
The patient should take all their other medications as prescribed.
Patient should allow at least 2 hours for the study.
There are no aftereffects and the patient can return to their usual activities immediately upon leaving the clinic.

Provider's Name: _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____