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| **NEUROLOGY SPECIALTY CARE CLINIC – REFERRAL FORM** |
|  **URGENT referral? – If yes, CALL OUR CLINIC for care coordination after forms are faxed.** |
| **PATIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **DATE:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  |
| **CHECK ONE BOX:** □ **EPILEPSY:** (Alan Stein, MD; Victoria Wong, MD, Leslie Rudzinski, MD) □ Epilepsy / seizure management (medical, surgical)  □ NeuroPace or VNS implantation / programming (circle one)  □ Epilepsy diet □ **NEURO-INTERVENTIONAL** :  □ Dr Samuel Tsappidi□ **ALS AND NEUROMUSCULAR:**(Vivian Chin, MD; Doug Miles, MD)  □ Consult  □ EMG, nerve conduction study, single-fiber EMG □ **VASCULAR NEUROLOGY** □ **PARKINSON’S DISEASE AND MOVEMENT DISORDERS:**(Michiko Bruno, MD; Fay Gao, MD) □ **GENERAL / OTHER:** □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Dementia / Cognitive Impairment / TBI / Headache **INSURANCE**Primary Insurance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary, if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If there is a THIRD PARTY PAYER, please include the adjuster’s authorization letter.**Please include the following with this referral:** □ Demographics cover sheet  □ Copy of the patient’s ID & insurance card(s) □ Insurance authorization or referral as appropriate  □ Clinic data to support the issues you want to address (H&P, clinic progress notes, prior diagnostic reports)  □ Brain imaging on disc or transmitted electronically | **CLINICAL SUMMARY:**Please provide a neurological reason for referral.**COMPLETE THE FOLLOWING INFORMATION:** **Neurologic diagnosis (ICD-10):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ One-time consult □ On-going careDOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ Male □ Female Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary contact phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**REFERRING PROVIDER**Referring provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is this a neurologist? □ Yes □ No Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PRIMARY CARE PROVIDER**Primary Care Provider (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

**We value your trust in our care. Mahalo for your referral.**