|  |  |
| --- | --- |
| **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 care  DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ 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.**