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.

☐ **Queen's Neurology:** Phone: 808-691-8866 I Fax: 808-691-8865
☐ **Queen's Neurosurgery:** Phone: 808-691-2727 I Fax 808-691-4127
☐ **Queen's Neurointerventional Surgery:** Phone: 808-691-2727 I Fax: 808-691-4127

Patient Information

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

Date of Birth: ______________________ MRN/SSN: ______________________

Home Phone: ______________ Work Phone: ______________ Mobile Phone: ______________

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/Parkinsons ☐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

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 for nerve block ☐Referral or transfer of care from another neurologist

Movement/Parkinsons

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

Neuromuscular/ALS/MG

☐Hospital follow up ☐Patient has a positive acetylcholine antibody, fasciculation/atrophy in muscle, or abnormality in EMG/CNS test ☐Referral for EMG/NCS ☐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 ☐Parkinsons 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

☐ Insurance Pre-Certification/Authorization

☐ Last (2) Office Visit Notes

☐ Pertinent Imaging Reports and DISCs (MRI, MRA, CT, CTA, etc.)

☐ Last (2) Neurology/Neurosurgery Notes

☐ Other Pertinent Records (EEG, EMG, Lab Results, Neuropsychology Notes, Physical Therapy Notes, etc.)

Referring Physician Printed Name: ____________________

Phone: ____________________ Fax: ____________________ Date: ____________________

Primary Care Physician Name: ____________________ Date: ____________________

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