

# Department of Neurology Referral Intake Form

**REQUIRED:** What is the clinical question you would like the doctor to answer: \_\_\_\_\_

Patient's (possible) neurological diagnosis ICD-10: \_\_\_\_\_

Brief description of pertinent symptoms: \_\_\_\_\_

**Indicate specialty:**

- General neurology  
(P: 206-320-3494 F: 206-320-2712)
- Neuromuscular/ALS  
(P: 206-320-3494 F: 206-386-2845)
- Stroke  
(P: 206-320-3278 F: 425-394-0578)
- Movement disorders  
(P: 206-320-5331 F: 206-386-3882)
- Epilepsy  
(P: 206-320-3492 F: 206-320-3088)
- Balance Center  
P: 206-320-3900 F: 206-320-3899)
- Neuro-ophthalmology  
(P: 206-386-2700 F: 206-386-2703)
- MS Center  
(P: 206-320-2200 F: 206-320-2560)

**Purpose of referral:**  Consult  Second opinion

**This visit is (mark one):**

- Routine / Next available: 30-45 days
- Medically urgent (If urgent, please have referring provider or R.N. call the corresponding office.)

**Insurance:**

Primary Insurance Company: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Member ID #: \_\_\_\_\_

**Patient information**

Patient name: \_\_\_\_\_  M  F Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Preferred phone number: \_\_\_\_\_ (Home / Cell / Other) OK to leave detailed voice message?  Y  N

Interpreter needed?  Y  N If yes, language: \_\_\_\_\_

**If your patient is unable to make the appointment for themselves, please list contact person:**

Patient contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referring provider**

Referring provider: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Primary care provider: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Please include PERTINENT chart notes and test results (i.e., neurology notes, brain imaging reports, labs, etc.) from the past six months that support the issues you want us to address and fax to corresponding specialty clinic number listed above.**