COMPREHENSIVE NEUROLOGY REFERRAL FORM

Neurosciences Clinic
213 Quarry Rd
Palo Alto, CA 94304
Phone: 650-723-6469 **Fax:** 650-320-9443

☐Routine ☐**URGENT**

REFERRING PROVIDER INFORMATION

Referred by (MD, DO, NP, PA): _____Form completed by:_____

Medical Group: _____ Email: _____

Phone:_____ Fax: _____ NPI: _____

Address: _____

City/ Zip Code: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB:_____/_____/_____ Phone: _____Gender: ☐M ☐F☐Nonbinary

Address/City/ State/ Zip: _____

_____Needs Interpreter? ☐Y ☐N Language: _____

Please provide all relevant notes and test results to expedite scheduling*

INFORMATION REQUIRED PRIOR TO SCHEDULING

☐ **Consultation Only** ☐ **Testing Only**
What is your clinical question? (Required)_____
Presumed Diagnosis/ Condition: _____
Please do not place ICD-10 codes*

2. Has the patient been evaluated by a Neurologist previously? ☐ Yes ☐ No

If yes, Name/Practice location of Neurologist: _____
☐ Check to confirm these records and additional relevant notes are provided for our review

3. Has the patient been evaluated by any other specialist for this condition? ☐ Yes ☐ No
If yes, Name/Practice location of Specialist:_____
☐ Check to confirm these records are provided for our review

4. Are there imaging/test results related to this condition (MRI,EMG/NCS)? ☐ Yes ☐ No
☐ Check to confirm these records are provided for our review. **Patient must provide reports and images on CD at/before time of appointment.**