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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.