UAMS NEUROLOGY CLINIC CONSULTATION REQUEST

Please fax this completed form and requested information to 501-686-7518

Patient Name: _____ **Age:** _____ **Sex:** M F **Date of Referral:**_____

Home Phone: _____ **Cell #:** _____ **Work #:** _____

Patient Birth Date: _____ **SS#:** _____

Patient Address: _____

Insurance: _____

Insurance Type: ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **Traditional** ☐ **Medicare** ☐ **Medicaid** ☐ **None/Self Pay**

Referring Physician: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Primary Physician: _____ **Address:** _____

Presumptive diagnosis _____ **Duration of Symptoms:** _____

Brief history of the neurological problem: _____

_____

_____

_____

Is the problem __ **Stable ?** __ **Improving?** ___ **Worsening? Over what period of time?** _____

Is the patient __ **Fully functional?** __ **Intermittently impaired?** ___ **Fully Disabled?** ___ **By this illness?**

Did this problem arise from a motor vehicle accident or workplace injury? Y N Date of injury: _____

Is this a Workman's Compensation case? Y N (May require special arrangement.)

Has the patient seen a neurologist previously for this problem? Y N Prior Neurologist: _____

Other medical problems: _____

_____

Please describe any abnormalities on neurological exam: _____

_____

_____

Referral to Specific Clinic:

- ☐ General Neurology
- ☐ Dementia/Alzheimer's
- ☐ Epilepsy Clinic
- ☐ Headache Clinic
- ☐ Movement Disorders / Parkinson's
- ☐ Multiple Sclerosis
- ☐ Neuromuscular / ALS / MDA
- ☐ Neuro-oncology Clinic
- ☐ Sleep Clinic (pending)
- ☐ Stroke Clinic
- ☐ Botox/Procedure Clinic
- ☐ Urgent Resident Clinic

Type of Referral:

☐ One time consultation (most cases)

☐ Consultation, management, and follow-up care

Time Frame:

☐ Next Available (within 3 months)

☐ Within 2 weeks

☐ Urgent (2-3 days)

If urgent, please call UAMS Physician Call Center at 501-686-8000. Press 1 for the Call Center, then Press 2 for the RN who will contact the neurologist on call.

☐ I am referring to the following specific neurologist: _____

☐ I am willing to accept an alternative referral if the patient is seen sooner or by a more appropriate specialist.

Please send a copy of your patient data sheet including insurance information with the appointment request.
Fax copies of all pertinent clinic notes and test reports to 501-686-7518 with this form.

Please ask the patient to hand deliver films or CDs of imaging studies at the time of the initial appointment.

Thank you for providing this detailed information. Your will be contacted to inform you when your patient has been scheduled.

APPOINTMENT SCHEDULED with Dr. _____on _____(date) at _____ (time)

☐ Faxed back to referring MD ☐ Patient contacted: ☐ by phone ☐ letter Date:_____ Initials:_____