

DIVISION OF NEUROLOGY REFERRAL REQUEST FORM

Division Phone: 323-361-2471 Referral Fax: 323-361-8988 Neurological Institute Website: <u>chla.org/neuro</u>

PATIENT INFORMATION		
Date:		
Patient Name:	DOB:	Sex:
Parent Name: Other Contact:		
Phone - Day: Phone - Night:		
Insurance:	Authorization #:	
Medi-Cal #: I	ssue Date: HMO	Insurance:
REASON FOR REFERRAL		
Is this an urgent referral? □ NO □	□ YES	
Is this a second opinion? \square NO \square	□ YES	
Indicate if this referral is for a specific provider:		
Reason for the referral and/or suspected diagnosis:		
Preferred Location: ☐ Sunset Campus ☐	🛘 Arcadia 🕒 Encino 🗀 Santa Monica	a □ South Bay □ Valencia
Please designate a program for the referral:		
☐ GENERAL NEUROLOGY	Headaches, Uncomplicated Epilepsy, Developmental Delay, Hypotonia, Microcephaly, Macrocephaly, Concussion, Other General Neurologic Conditions	
□ NEURO-IMMUNOLOGY	Multiple Sclerosis, ADEM, Transverse Myelitis, Opsoclonus Myoclonus Syndrome, Other Neuro-Immunologic Disorders	
☐ MOVEMENT DISORDERS	Cerebral Palsy, Baclofen Pump, Botox Injections, Dystonia, Choreoathetosis, Other Abnormal Movements	
☐ TIC DISORDERS	Tic Disorders, Tourette Syndrome	
☐ NEUROCUTANEOUS DISORDERS	Neurofibromatosis, Tuberous Sclerosis, Sturge Weber, Other Neurocutaneous Disorders	
☐ NEUROMUSCULAR	Muscular Dystrophy, Myopathy, Peripheral Nerve Disorders (CMT), Myasthenia Gravis, Spinal Muscular Atrophy	
Request for EMG/NCV:		
☐ EMG/NCV		
Referring M.D. Signature (required if requesting for an EMG/NCV): Date/Time:		
☐ NEW ONSET SEIZURE CLINIC**	New Onset Seizures, Concerns for Seizures or Spells in Developmentally Normal Children, Febrile Seizures	
☐ INTRACTABLE EPILEPSY**	Patient is on 2 or More Anticonvulsants and Still Experiencing Seizures □ Epilepsy Surgery Evaluation	
	□ Ketogenic Diet	
□ Vagus Nerve Stimulator **An EEG order is required for referrals to these two programs, please check an EEG option in prescription below:		
☐ EEG Routine Sleep Deprived ☐ Video/EEG (4-6 Hours)		
Referring M.D. Signature (required if requesting an EEG): Date/Time:		
PROVIDER INFORMATION		
Requesting Provider Name: Date:		
Office Address:		
Office Phone: Office Fax:		
Please fax this referral to 323-361-8988 and include: This completed form Medical records relevant to this referral Copy of the patient's insurance card and authorization when applicable Patient Label		