Clear Form

Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Department of Neurology Consultation Request

Phone: 414-266-3464 • Fax: 414-266-1879

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Thank you for referring your patient to the Department of Pediatric Neurology.

- **If a Pediatric NEUROSURGERY consultation is requested, please do not use this form. Call 414-266-6435.**
- **Neurology does not treat ADHD/ADD, behavior problems or cerebral palsy.**

To expedite appointment scheduling, please provide the following

- This completed form
- Medical records related to the chief complaint
- Prior neurology records
- Previous EEG, CT or MRI results

Patient Information

Does patient live with someone other than the legal guardian?

☐ Yes (Relationship _____) ☐ No

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Home Phone Number: _____

Work Phone Number: _____

Cell Phone Number: _____

Insurance Carrier: _____

Referring Provider Information

Provider Name: _____

Provider Address: _____

_____

Phone Number: _____

Fax Number: _____

1. Is this an emergent neurological referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD/PA/APN/RN with clinical information to 414-266-3464**.
2. Please describe the patient's chief complaint and include onset and frequency.

   _____

   _____

   _____

   _____

3. If requesting a specific provider, please indicate their name here. Provider _____

   Please select one of the following clinics

☐ Comprehensive Epilepsy	To qualify for this clinic: Tried 2 or more medications and still experience seizure activity; epilepsy surgery eval
☐ General Neurology	Includes but not limited to tic disorder, tremor, seizures, headaches, hypotonia, microcephaly
☐ Headache	To qualify for this clinic: Tried one preventative medication and/or one abortive medication. For frequent school absences consider a referral to the pain clinic.
☐ Movement Disorder	Dystonia, chorea, ataxia
☐ Muscular Dystrophy	Spinal Muscular Atrophy; Duchenne's; peripheral neuropathy disorder, Myasthenia Gravis, myotonia
☐ Stroke	

4. What is the key question you want us to answer?

   _____

   _____

Referring Provider Signature: _____ Date: _____ Time: _____ **(Required)**

APPLY DT BARCODE STICKER
MD Referral Accepted DT 346
MD Referral Denied DT 9901

Print Form