Department of Neurology Consultation Request

Phone: 414.266.3464 • Fax: 414.266.3466

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Thank you for referring your patient to the Department of Pediatric Neurology. Please complete the following information and provide medical records related to the chief complaint including prior neurology records, previous EEG or MRI results so that we can provide the best and most timely service.

If a Pediatric NEUROSURGERY consultation is requested, please do not use this form. Call 414.266.6435.

ADHD/ADD and Behavior problems referrals please call 414.607.5280

Patient Information

Does patient live with someone other than the legal guardian? ☐ Yes ☐ No

Patient Name: ______________________

Parent/Guardian Name(s): ______________________

Patient Address: ______________________

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Date of Birth: ______________________

Home Phone Number: ______________________

Work Phone Number: ______________________

Cell Phone Number: ______________________

Insurance Carrier: ______________________

Needs Referral: ☐ Yes ☐ No (Central Scheduling use only)

Referring Provider Information

Provider Name: ______________________

Provider Address: ______________________

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Phone Number: ______________________

Fax Number: ______________________

1. Please describe the patient's chief complaint and include onset and frequency

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Severity of Problem ☐ Mild ☐ Moderate ☐ Severe (been to Emergency Room or out of school)

2. Level of urgency: ☐ Within 1 week (emergency REQUIRES PHONE CALL TO 414.266.3464),
☐ Within 6 weeks (has some urgency),
☐ Next available (2nd opinion, problem currently being managed, no urgency)

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

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Please sign and fax this form with medical records to 414-266-3466. When the form and records are received, your request will be reviewed and processed. You will receive communication from our office regarding the status of the appointment.

Referring Provider Signature: ______________________ Date/Time: ______________________

OFFICE USE ONLY
Referral Status
☐ Schedule Appointment with ______________________ Timeframe: ______________________
☐ Referral sent to ______________________ on ______________________
☐ Sent letter to referring suggesting referral to ______________________ on ______________________

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

C7141N (7/08)