uchealth

Department of Neurology Referral Intake Form - To be completed by referring health care provider

REQUIRED: What is the clinical question you would like the neurologist to answer? ____
____

Patient's (possible) neurological diagnosis: ____

Brief description of pertinent symptoms: ____
____

Purpose of referral: ☐ Initial Consult ☐ Second opinion

Indicate specialty:

☐ General Neurology: Appropriate for initial evaluation and management of neurological symptoms

☐ Subspecialty Neurology: Appropriate for patients with diagnosed neurological conditions needing a higher level of care OR patients without diagnoses despite previous neurological evaluations

- ☐ Cognitive Neurology: Dementia, cognitive decline
- ☐ Epilepsy
- ☐ Headache/Migraine
- ☐ Moderate/Severe Traumatic Brain Injury (excludes concussion/mild TBI)
- ☐ Movement Disorders: Parkinson's, dystonia, tics, ataxia
- ☐ Movement Disorders: Deep Brain Stimulation and Advanced Therapies
- ☐ Neuro-immunology: Multiple sclerosis, NMO, myelitis, encephalitis, CNS vasculitis
- ☐ Neuromuscular: myopathy, muscular dystrophy, myasthenia gravis, Guillain-Barre, CIDP, hereditary neuropathy
- ☐ Neuro-oncology
- ☐ Neuro-ophthalmology
- ☐ Neurovascular: Stroke, ICH, SAH occurring in the past 6 months
- ☐ Sleep Neurology: Narcolepsy, restless leg syndrome, insomnia, central sleep apnea
- ☐ Time Sensitive Diagnoses (reviewed immediately for ASAP appt): ALS/motor neuron disease, rapidly progressive dementia (<12 months), autoimmune encephalitis, trigeminal neuralgia or cluster headache with active pain, Huntington's disease, neuro symptoms in pregnancy)

Records: Please attach any pertinent clinical notes, medication lists, and recent lab work.

Has the patient had any imaging of the brain and/or spinal cord (CT or MRI)? ☐ Y ☐ N

If yes, images must be pushed to UCHealth via PowerShare prior to appointment scheduling.

Imaging facility where CT/MRI performed: ____

Patient information

Patient name: ____ M F Date of birth______/______/______

Address: ____ City: ____________________ State: ________ ZIP:_________

Preferred phone number: _______________________________

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: _____________________________________ Primary care provider: ____________________________________

Phone: ____________________________Fax: ______________ Phone:_______________________ Fax:______________________

Address: ____ Address:____

City: ______________________ State: _____ ZIP:____________ City: ______________________ State: _____ ZIP:_____________

Return By Fax to UCHealth Neurosciences Department Fax: 720-848-2106 Main Phone: 720-848-2080