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: Alzheimer's disease, Lewy body dementia, frontotemporal dementia ☐ Anti-Amyloid Therapies
- ☐ Epilepsy: Complex epilepsy and seizure syndromes, surgical epilepsy evaluations
- ☐ Headache/Migraine: Refractory migraine, trigeminal autonomic cephalgia, trigeminal neuralgia
- ☐ Moderate/Severe Traumatic Brain Injury (**excludes** concussion/mild TBI, brain injury requiring hospitalization/ICU/rehab stay)
- ☐ Movement Disorders: Parkinson's, dystonia, tics, ataxia
- ☐ Movement Disorders: Deep Brain Stimulation and Advanced Therapies
- ☐ Multiple Sclerosis
- ☐ Neuromuscular: Myopathy, muscular dystrophy, myasthenia gravis, Guillain-Barre, CIDP, hereditary neuropathy
- ☐ Neuro-oncology: Brain and nerve tumors
- ☐ Neuro-ophthalmology: Cranial nerve palsies, visual field defects, diplopia
- ☐ Neurovascular: Stroke, cerebral hemorrhage, cerebral vascular malformations
- ☐ Autoimmune Neurology: Autoimmune/paraneoplastic encephalitis, stiff person syndrome, CNS vasculitis, neurosarcoidosis
- ☐ 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: **720-848-0015** Main Phone: 720-848-2080