

## NEUROLOGICAL INSTITUTE PHYSICIAN REFERRAL

## Preferred methods of communication

Supply us with your patient's medical records in one of these ways:

Fax: 216.636.2596 Phone: 216.445.8455 Or mail to: Cleveland Clinic, T1-203 9500 Euclid Ave. Cleveland, OH 44195

Asterisk (\*) indicates a required field needed to complete the referral request.

Date	Type of Reservation 🗌 Regular	Urgent (as soon as possible)		
Purpose Diagnosis	Surgery Other (specify)	,		
Please Identify the Subspecialist to be Seen*	<ul> <li>Behavioral Health/Psychiatry</li> <li>Brain Health/Dementia</li> <li>Brain Tumor/Neuro-Oncology</li> <li>Cerebrovascular</li> <li>Epilepsy</li> </ul>	<ul> <li>Headache &amp; Facial Pain</li> <li>Movement Disorders</li> <li>Multiple Sclerosis</li> <li>Neuromuscular</li> <li>Pediatric Neurosciences</li> </ul>	<ul> <li>Physical Medicine &amp; Rehabilitation</li> <li>Sleep Disorders</li> <li>Spine Health</li> </ul>	
Reason for Referral (diagnosis or symptoms; DO NOT enter ICD codes here):				
Are you requesting a specific provider? Yes No If yes, please indicate				
Patient Name*			DOB	
Street Address		City	State	Zip code
Patient Phone*				
		Subscriber Name: ID#:	Group#:	
Please send copies of insurance cards for verification purposes				
Referring Physician*			Phone*	
Referring Physician Preferred Fax #		Referring Physician Practice Name		
Past Test Results and Visit Notes Related to this Referral (if available, please check and submit the records)	Angiogram CT CTA Echo EEG EKG EKG HSAT	Ictal SPECT  MEG MRI PET PSG Rhythm monitoring Ultrasound	<ul> <li>Significant labs: lipid panel, HbA1c, hypercoag panels, LP studies</li> <li>Neurological office visit notes (including H&amp;P)</li> <li>Previous neurosurgical records (if referral is to surgery)</li> <li>Hospital discharge summary</li> <li>Other</li> </ul>	