BRAIN INSTITUTE
*Oregon Health & Science University*

School of Medicine
Department of Neurology

Mail code L226
3181 SW Sam Jackson Park Rd.
Portland, Oregon 97239-3098

TEL: 503 494-7772

FAX: 503 494-8390

# Thank you for referring your patient to the OHSU Department of Neurology

We appreciate the referrals that come to us from physicians and other health care providers from Oregon, SW Washington and beyond. Our aim is to make the referral process as seamless as possible. Receipt of the Referral Intake form will assist us in expediting the processing of your referral.

Because of the volume of requests we receive for neurological consultations, ongoing and long-term care is not guaranteed, and is provided at the discretion of our physicians.

We will initiate contact with your patient and will notify you when the appointment is scheduled. If we are unsuccessful in reaching your patient to schedule an appointment, we will contact your office.

## General items of note:

**MVAs, Worker's Compensation, IMEs, and Third Party Litigation referrals are typically not seen in the Comprehensive Neurology Clinic at OHSU.**

**Disability determinations are not seen or diagnosed in the Comprehensive Neurology Clinic.**

**Neurology does not provide general outpatient Neuropsychological testing.**

**Neurology does not offer a chronic neurological pain management program. For chronic neurological pain management please contact the OHSU Comprehensive Pain Center at 503 494-7246.**

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# Department of Neurology Referral Intake Form

**What is your clinical question?**_____

_____

_____

Date: _____

- ☐ Comprehensive (General)
- ☐ Aging & Alzheimer's
- ☐ Multiple Sclerosis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Neuromuscular/ALS
  - ☐ biopsy
- ☐ Movement Disorders/Parkinson's
  - ☐ deep brain stimulation

## Insurance

All insurance coverage must be provided and authorization obtained before we can schedule.

Primary Ins. Co._____

Policy#_____

phone#_____

Scndry Ins. Co. _____

Policy#_____

phone#_____

If authorization required:

Auth #:_____

_____

No. of Visits: _____
(Initial plus 1 follow-up)

Dates Effective: _____

Date Expires: _____

Please fax copy of the patient's insurance card and authorization document, thank you.

## Patient

Patient's Neurological Diagnosis: (ICD-9) _____
☐ Consult Only ☐ On-going Care

Please include chart notes & diagnostic reports from the past 6–9 months that support the issues you want us to address.

Patient's Full Name:_____

DOB:_____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

☐ Male ☐ Female SS#: _____

If your patient is unable to make appt for themselves please list contact person below:

Patient contact: _____ Relation: _____

hm ph: _____ wk/cell/other:_____

## Referring Provider

Referring Provider: _____

Phone:_____ Fax:_____

Address: _____

City: _____ State: _____ Zip:_____

Neurologist: ☐ Yes ☐ No

## Primary Care Physician

Primary Care Physician: _____

Phone:_____ Fax:_____

Address: _____

City: _____ State: _____ Zip:_____