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.
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: _______

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