CHOC Children's Specialists

Division of Neurology Referral Request

Division Phone: 714.509.7601 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Neurology.

- If a Pediatric *NEUROSURGERY* consultation is requested, please do not use this form, call 714.509.7070

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance : _____ Parent Cell: _____

1. Is this an **emergent** neurological referral? ☐ No ☐ Yes **If yes, requires a phone call from an MD /PA /NP with clinical information to 714.509.7601**

2. Please describe the patient's chief complaint and *include onset and frequency*:

_____

_____

_____

_____

3. What is the key question you want us to answer?_____

_____

_____

4. Please select one of the following:

☐ **Intractable Epilepsy**	To qualify for this clinic: Tried 2 or more medications and still experiencing seizures; epilepsy surgery evaluation
☐ **General Neurology**	Includes but not limited to: headaches, hypotonia, microcephaly, developmental delay, epilepsy, tremors, concussion
☐ **Neuromuscular Disorders**	Spinal Muscular Atrophy; Duchenne's; peripheral neuropathy, Myasthenia Gravis, myotonia, multiple sclerosis

To expedite appointment scheduling, please provide the following by FAX 855-246-2329:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Prior neurology records including EEG, CT, or MRI result - see referral guidelines for details** http://www.choc.org/referralguidelines
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____