Child Neurology SOLUTIONS

NAME OF PATIENT _____
DOB _____

ROUTINE CONSULT REQUEST FORM

DATE_____
Reason for referral?

Urgency? If ASAP or Urgent please call Dr. Gilles at (651) 302-7737

Is this problem progressive? _____ Yes No
Does this child see a neurologist currently? Yes No If yes, is this a second opinion? Yes No
Will the parents need an interpreter? Yes No Language? _____

CONTACT INFORMATION

Name of parent(s)/guardians _____
Address _____ City _____ State _____ Zip _____
Home # _____
Work # (Mom Dad) _____ Cell (if applicable) _____

Primary Provider Name _____ Clinic Name _____
Address _____ City _____ State _____ Zip _____
Ph # ( )_____ Fax # ( )_____ email _____

Referring Provider Name (if different from primary) _____ Clinic Name_____
Address _____ City _____ State _____ Zip _____
Ph # ( )_____Fax # ( )_____ email _____

INSURANCE INFORMATION

Insurance: _____ Policy Holder: _____
ID#: _____ Group #: _____ Employer: _____

FOR CLINIC USE ONLY

Referral form received (date/time): _____
Reviewed (date/time/init): _____**Accepted for Clinic**: **Yes** **No** **Call back** (date/time/init): _____

Appointment Date _____**Time** _____
Records needed:
Birth records Hospital records EEG reports Educational reports Rehab therapy reports
Clinic notes Imaging studies Other: _____

Parent/guardian contacted: Date _____
Information given verbally or emailed re how to set up patient portal Yes
Release of information received:_____(date/time)
Records and imaging requested:_____(date/time)