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 Neuropsychological testing**
- **Neurology does not offer a chronic neurological pain management program**

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REFERRAL INTAKE FORM

Date: _____

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

What neurological related issues are you wanting addressed?:_____

_____

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

Consult Only ____ On-going Care ____

Patient's Neurological Diagnosis: (ICD-9) _____

Patient's Full Name:_____ DOB:_____

Address: _____ _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Male: _____ Female: _____ SS#: _____ Cell Phone :_____

IF YOUR PATIENT IS UNABLE TO MAKE APPT FOR THEMSELVES PLEASE LIST CONTACT PERSON BELOW

Patient contact: _____ *Relation:*_____ *hm ph*: _____ *wk/cell/other:*_____

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

Primary Ins. Co._____ Policy#_____ phone#_____

Secondary Ins. Co. _____ Policy #_____ phone#_____

If authorization required; Auth #:_____

No. of Visits: _____ (Initial plus 1 f/u) Dates Effective: _____ Date Expires: _____

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

Referring Provider: _____ Phone:_____Fax:_____

Address: _____City: _____ State: _____ Zip: _____

Neurologist: _____ Yes _____ No

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Primary Care Physician: _____Phone:_____Fax:_____

Address: _____City: _____ State: _____Zip: _____