UNIVERSITY OF IOWA HEALTH CARE

Department of Neurology

Balance Clinic Referral Form

Patient Centered Care by a World Class Team for Quality Lives

Fax to Secure E-mail:
UIHC Neurology Clinic
Attn: Neurology Clinic
Phone: 319-356-2572
E-fax: 319-356-4505

Mail: *(if needed for imaging)*
UIHC Neurology Clinic
Attn: Neurology Clinic
200 Hawkins Drive
Iowa City, IA 52242

Referral Date: _____

Patient Name: _____ MRN: *(internal)* _____

Address: _____ DOB: _____ Age: _____

City, State, Zip: _____ Phone #: _____

Insurance: _____ Policy #: _____

Referring Physician: _____ **Specialty:** _____

Address: _____ NPI #: _____

Referring Physician Phone: _____ Fax: _____

PCP: _____ Address: _____
(if different than referring physician)

Contact Person/Phone: _____

Please answer the following questions ***(***Required***)***:

- Has this patient been evaluated by a neurologist? ☐ Yes ☐ No
- Has the onset of dizziness been present for more than 2 years? ☐ Yes ☐ No
- Has the patient received vestibular rehabilitation? ☐ Yes ☐ No
- Please send the following Records(N/A if records do not exist)
  - All Neurology and other relevant clinic notes ☐ Yes ☐ N/A
  - All ENT relevant clinic notes ☐ Yes ☐ N/A
  - Brain and spine imaging CD sent to us ☐ Yes ☐ N/A
  - Vestibular Therapy Notes ☐ Yes ☐ N/A
- **Specific Clinic Question to be Answered:**

_____

_____

_____

Appointments may only be scheduled after ALL medical records have been received.

Thank you for referring your patient to the UIHC Neurology Clinic.