Children's Hospital LOS ANGELES

DIVISION OF NEUROLOGY REFERRAL REQUEST FORM

Division Phone: 323-361-2471 **Referral Fax:** 323-361-8988

Neurological Institute Website: *chla.org/neuro*

PATIENT INFORMATION

Date: _____

Patient Name: _____ **DOB:** _____ **Sex:** _____

Parent Name: _____ **Other Contact:** _____

Phone - Day: _____ **Phone - Night:** _____

Insurance: _____ **Authorization #:** _____

Medi-Cal #: _____ **Issue Date:** _____ **HMO Insurance:** _____

REASON FOR REFERRAL

Is this an urgent referral? ☐ NO ☐ YES

Is this a second opinion? ☐ NO ☐ YES

Indicate if this referral is for a specific provider: _____

Reason for the referral and/or suspected diagnosis: _____

Preferred Location: ☐ Sunset Campus ☐ Arcadia ☐ Encino ☐ Santa Monica ☐ South Bay ☐ Valencia

Please designate a program for the referral:

☐ **GENERAL NEUROLOGY**	Headaches, Uncomplicated Epilepsy, Developmental Delay, Hypotonia, Microcephaly, Macrocephaly, Concussion, Other General Neurologic Conditions
☐ **NEURO-IMMUNOLOGY**	Multiple Sclerosis, ADEM, Transverse Myelitis, Opsoclonus Myoclonus Syndrome, Other Neuro-Immunologic Disorders
☐ **MOVEMENT DISORDERS**	Cerebral Palsy, Baclofen Pump, Botox Injections, Dystonia, Choreoathetosis, Other Abnormal Movements
☐ **TIC DISORDERS**	Tic Disorders, Tourette Syndrome
☐ **NEUROCUTANEOUS DISORDERS**	Neurofibromatosis, Tuberous Sclerosis, Sturge Weber, Other Neurocutaneous Disorders

☐ **NEUROMUSCULAR**	Muscular Dystrophy, Myopathy, Peripheral Nerve Disorders (CMT), Myasthenia Gravis, Spinal Muscular Atrophy

Request for EMG/NCV:

☐ EMG/NCV

M.D. Signature (required): _____ **Date/Time:** _____

☐ **NEW ONSET SEIZURE CLINIC****	New Onset Seizures, Concerns for Seizures or Spells in Developmentally Normal Children, Febrile Seizures
☐ **INTRACTABLE EPILEPSY****	Patient is on 2 or More Anticonvulsants and Still Experiencing Seizures; Epilepsy Surgery Evaluation; Ketogenic Diet; Vagus Nerve Stimulator

An EEG order is required for referrals to these two programs, please check an EEG option in prescription below:

☐ EEG Routine Sleep Deprived ☐ Video/EEG (4-6 Hours)

M.D. Signature (required): _____ **Date/Time:** _____

PROVIDER INFORMATION

Requesting Provider Name: _____ **Date:** _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Please fax this referral to 323-361-8988 and include:

- This completed form
- Medical records relevant to this referral
- Copy of the patient's insurance card and authorization when applicable

Patient Label