PHYSICIANS' CLINIC
of Iowa, P.C.

REQUEST FOR CONSULTATION OR TRANSFER OF CARE

Please complete the form below and fax to PCI Neurology and Sleep Medicine Clinic at 855-428-0487.

REFERRING PROVIDER INFORMATION

Referring Provider Name _____ Date _____

Contact Name _____ Contact's Direct Phone Number _____

Contact Fax Number _____

PATIENT INFORMATION *(or demographic sheet)*

Date of Birth _____ Gender: ☐ Male ☐ Female

First Name _____ Last Name _____

Parent's Name (if minor)_____

Home Address _____ City _____ State _____ Zip_____

Primary Phone Number _____ Secondary Phone Number _____

Contact Instructions (i.e. best time to reach, OK to leave a message, text or email preference, etc.) _____

_____

Emergency Contact Name _____ Emergency Contact Number _____

Insurance Plan Provider/Coverage _____

Email address: _____

REQUESTED APPOINTMENT

☐ Urgent ☐ Routine

☐ Consultation—Request for opinion/advice.

☐ EMG testing

Reason for referral, symptoms, and diagnosis (please be specific and state the area of involvement) _____

_____

_____

Previous work up or neurologist: _____

Previous testing: EMG, EEG, MRI: location of testing. Must have CD w/ images if done outside of Cedar Rapids _____

Attach records and recent lab results (must have documents to review to approve for scheduling) _____

Is this a work injury or a third party liability case? ☐ Yes ☐ No

Appointment notification instructions

☐ Contact patient with appointment date/time ☐ Special Instructions _____

☐ Contact referring office with appointment date/time, referring office will notify patient of appointment date/time.

Appointment date:_____ Arrival time:_____ Scheduled with:_____

Patients should bring an updated list of their medications, insurance cards, photo ID to the appointment.

Thank you for allowing us to participate in caring for your patient. We will contact you regarding this referral within 72 hours.

PCI Neurology & Sleep Medicine | 275 10th Street SE, Suite 3320, Cedar Rapids, IA 52403 | (319) 398-1721