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.) ______________________________

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Emergency Contact Name ______________________________ Emergency Contact Number ______________________________

Insurance Plan Provider/Coverage ______________________________

Email address: ______________________________

REQUESTED APPOINTMENT

☐ Urgent ☐ Routine *For emergent consult needs please, have provider contact the on call neurologist at (319) 369-8954, pager number 9520.*

☐ Consultation—Request for opinion/advice.

☐ EMG testing

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

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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