Iowa NEUROLOGY & SLEEP, PLC

QR Code iowaneurologyandsleep.com

REFERRAL FORM

Patient Name_____DOB_____

Address_____Phone_____

Diagnosis/Chief Complaint_____Insurance_____

Referring Provider_____Phone_____

☐Neurology Consult

Reason for Consult_____

_____

☐EMG/Nerve Conduction Extremities_____Weight_____

****PATIENT MUST BE ABLE TO GET ON AND OFF EXAM TABLE WITHOUT ASSISTANCE****

****OUR EQUIPMENT HAS A WEIGHT LIMIT OF 325 POUNDS****

Is this work comp? ☐YES ☐NO (If yes, then work comp information must be sent with form.)

Please include the following items: (**WE WILL NOT SCHEDULE UNTIL ALL INFORMATION IS RECEIVED.)**

- Patient demographics and insurance card
- Hospital/ER notes
- MRI/CT reports (send disc or push images to SEIRMC)
- Clinical notes
- Lab test results
- Medication list
- Previous neurology notes
- Prior EEG or EMG results

*****PLEASE COMPLETE FORM AND FAX ALL INFORMATION TO 844.676.1363*****

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