McFarland Clinic

Neurology Referral Form
1015 Duff Ave, Ames, IA 50010
515-239-4435 Fax: 515-239-4758

Form must be filled out completely *Fax 515-239-4758*

Referral Date: _____ Referral Diagnosis: _____

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

Address: _____ DOB: _____ Age: ____

City, State, Zip: _____ Phone #: _____

Referring Physician: _____ Specialty: _____

Address: _____ NPI #: _____

Referring Physician Phone: _____ Fax: _____

Contact Person to Schedule appointment _____

Phone: _____ Relationship:_____

- Has this patient been evaluated by a neurologist? Yes No
  - If yes, please send **neurological records** including clinical notes and **test results** including reports. *(e.g. blood work, MRI's, EMG/NCV, EEG's, etc). Please have patient bring pertinent imaging on disc.*
- Interpreter Needed? ____Yes ____No If Yes, what language_____
- Is this Work Comp? ____Yes ____No
  - If Yes, send all work comp billing information with approval by case manager to be seen by Neurology.

Preferred Provider _____Preferred Location:_____

CLINICAL QUESTION TO BE ANSWERED:*(Please include specific symptoms and diagnosis)*

_____

_____

Check mark all records sent (All information is needed to schedule appointment)

- ❑ *Patient demographics and insurance cards (front and back)*
- ❑ *Clinic Notes, Hospital/ER notes*
- ❑ *Previous Neurologist records*
- ❑ *Lab tests relevant to referral reason*
- ❑ *Medication List*
- ❑ *MRI/CT reports (Images required)MUST have MRI/CT images for appt*
- ❑ *Care EveryWhere access given _____Yes _____ No*
- ❑ *MRI/CT Images pushed to McFarland _____Yes _____No*

Thank you for your referral to McFarland Neurology Department Form Revised 8/1/19