



## Neurosciences New Patient Referral Request Form

Phone: 402.559.8600 | Fax: 402.559.0598

Patient name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Reason for referral/ diagnosis:

*(Please be specific to ensure we can get the patient scheduled with the correct provider and subspecialty for their symptoms.)*

Is there any previous/known neurological diagnosis: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

When was the patient last seen by the referring office (MM/YY)? \_\_\_\_\_

Priority status: Routine (next available): \_\_\_\_\_ Urgent (provider review): \_\_\_\_\_

Patient needs an appointment with:

Stroke/Vascular Neurology      Memory Disorder      Multiple Sclerosis/ Neuroimmunology

General Neurology      Epilepsy      Movement Disorder

Neuromuscular      Specific provider request: \_\_\_\_\_

**\* To proceed with processing this new patient referral, please send the following information along with this form:**

*(New patient referrals **will not** be processed until all available information is received.)*

- Thorough patient demographics/insurance cards
- Office notes concerning this neurological issue from the last 10 months
- All office notes specific to the neurological history
- Labs from the last 12 months
- MRI/CT scans of brain/spine. If available, please push all images to UNMC Powershare/PACS
- EMG/EEG/LP
- Neuropsychological testing reports/psych evaluations
- Sleep studies/autonomic/genetic testing
- Cardiology reports
- Mayo and or other specialty hospital/clinic reports

**Please email all records and referral to: [neuroreferral@nebraskamed.com](mailto:neuroreferral@nebraskamed.com)**

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