CARILION CLINIC

NEUROLOGY APPOINTMENT REQUEST FORM

Please include the last 5 office visit notes, problem specific imaging reports (x-ray, MRI, CT), and any labs completed within the past 6 months.

PATIENT INFORMATION

Patient Name (First, MI, Last): _____

Date of Birth:_____ Preferred Language: _____

Address: _____

Telephone (Home):_____(Cell):_____(Work): _____

Insurance Coverage:_____ ID#: _____

Work Comp or VA Referral? Yes or No Date of Injury:_____(if applicable)

Reason for Referral (please circle):

Consultation **Test/Procedure:** _____

Priority of Appointment (please circle one below):

Urgent See w/in 2 days See w/in 7 days See w/in 14 days See w/in 30 days Routine

General Neurology:

Abnormal Brain MRI	Syncope & Collapse	Dizziness (vertigo)
Altered Mental Status	Weakness	Dysphagia
Alzheimer's	Balance Problems	Frequent Falls
Ataxia	Bell's Palsy	Leukoaraiosis (White Matter Disease)
Balance Problems	Cerebral Amyloid Angiopathy	Memory Loss
Neurofibromatosis	Dementia	Myelopathy
Speech & Language Deficits		

Updated: 12/2024

Movement:

Chorea	Tardive Dyskinesia	Torticollis
Dystonia	Gait Difficulty	Wilson's Disease
Essential Tremor	Tics	Parkinson's Disease
Tremor	Tourette Syndrome	Huntington's Disease
Restless Leg Syndrome	Spino-Cerebellar Degeneration	Stiff Person Syndrome

MS/ Immunology:

Multiple Sclerosis	Autoimmune Encephalitis	Neuromyelitis Optica Syndrome
Transverse Myelitis	Behcet's Disease Syndrome	Sjogren's Syndrome with Neurological Manifestations
Neurosarcoidosis	Paraneoplastic Syndrome	Systemic Lupus Erythematosus with Neurological Involvement

Neuromuscular:

Carpal Tunnel Syndrome	Inclusive Body Myositis	Paresthesia
Charcot Marie Tooth Disease	Lou Gehrig's Disease (ALS)	Peripheral Neuropathy
Chronic Inflammatory Demyelinating Polyneuropathy	Muscular Dystrophy	Polymyositis
Diabetic Neuropathy	Myasthenia Gravis	Post Herpetic Neuralgia
Guillan-Barre Syndrome	Myopathy	Neuropathy
Idiopathic Peripheral Neuropathy		

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Vascular/Stroke:

Acute Ischemic Stroke	Chronic Stroke Management	Transient Vision Loss
Cavernoma	Spasticity (Post Stroke Treatment)	Hemiparesis (Late Effect of Stroke)
Cerebral Infarct	Stroke Mimics	Hemorrhagic Stroke
Post Stroke Sequelae	Stroke or Cerebrovascular Accident	Intracranial Hemorrhage
Cerebrovascular Accident (History)	Transient Ischemic Attack (TIA)	

Headaches: Special Instructions for Headache Referrals:

When referring for headaches, please consider the following due to prolong wait times:

- Avoid Increasing Headache frequency (medication over-use headaches) by limiting use of OTCs (APAP/NSAIDS) <15 days a month
- Consider triptans (Imitrex 50-100mg, Maxalt 5-10mg are broadly tolerated) when OTCs are ineffective
    - Limit Triptans and combination analgesics (e.g., Excedrin) to fewer than 9 days/months to avoid MOH
    - Foricet and opioids are discouraged
- Patients with more than 9 headaches per day/month, or triptan resistance/contraindication benefit from daily preventive therapy.
    - The following are commonly used and well tolerate preventative therapies:
        - Propranolol 60-120mg daily div. BID-TID titrated 2-4 weeks
        - Amitriptyline 25-50mg nightly titrated over 2-4 weeks
        - Adjunct: Magnesium glycinate 500 mg nightly (no need for titration)

Benign Intracranial Hypertension	Rebound Headache	Pseudotumor Cerebri
Chronic Daily Headaches	Headache	Trigeminal Neuralgia
Cluster Headache	Migraine	Occipital Neuralgia
Tension Headache		

Seizure/Epilepsy:

Absence Seizure	Juvenile Myoclonic Epilepsy	Seizure Disorders
Focal Seizure	Primary Generalized Epilepsy	Seizure Like Activity
Generalized Tonic- Clonic Seizure	Seizure	

Specialty Review: any diagnosis that is not listed above, please write in:

_____

**For conditions not listed on this form, please call 540-224-5170 and ask for neurology scheduling to verify if the condition is treated by this practice. **

Has the patient had prior medical care for this problem in the same specialty? Yes or No

Who did the patient see? _____

Is patient still established with that provider? Yes or No

First Available or Specific Physician: _____

(specific physician could delay in scheduling time)

REFERRING PHYSICIAN OFFICE INFORMATION:

Provider Referring the Patient:

_____

Office Contact Name:_____Contact Fax Number: _____

Office Phone Number: _____

Please fax the referral cover sheet and medical records to 540-857-5309.

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