Ascension St. John

Ascension St. John Neurology

Referral Form

This form is intended to assure prompt communication with requesting providers.

IMPORTANT: Fax recent office notes in relation to neurological referral.

General conditions

- Cognitive and Memory Disorders
- Epilepsy/Seizure Disorders
- General Neurological Conditions
- Movement Disorders
- Neuromuscular Disease
- Stroke

Fax: 918-403-6437

Physician and patient information

Patient name: _____ Date: _____

Patient telephone: _____ Date of birth: _____

Referring physician: _____ Telephone: _____

Primary insurance*: _____ Policy#: _____

** Visit our website for a full list of insurance providers accepted by Ascension St. John.*

Insurance requires pre-authorization: ☐ Yes ☐ No Referral #: _____

Reason for neurological/neuropsychological referral: _____

Referral criteria

☐ Cognitive and Memory Disorders
☐ Epilepsy
☐ General Neurological
☐ Movement Disorders
☐ Neuromuscular/EMG
☐ Stroke

Type of referral

☐ Concurrent care/office visit
☐ Consultant assumes care/office visit
☐ EMG
☐ One-time consultation/office visit

Has there been any previous testing? ☐ Yes ☐ No

If yes, when and where?

_____

_____