Referral to Gundersen Health System Neurology

Fax this completed form to Neurosciences Schedulers Fax (608) 775-5263
Records must accompany this referral. Please include documentation, such as: imaging report; copies of images sent via PACS or CD; last notes pertaining to referral reason; lab results; current medications; allergies; etc. ***If this is not included, the referral will be sent back.**

Fax Medical records to Health Information Management/Medical Records (608) 775-4706

Patient information

Patient name: _____ Gender: _____

Patient address: _____

Date of birth: _____ Email: _____ Phone number: _____

Insurance name: _____
(please include copy of front and back of insurance card):

Referring provider information

Referring provider name/address: _____

Phone number: _____ Fax number: _____ Patient's PCP name/address: _____

Appointment request

Reason for referral and outcome you are requesting: _____

_____

Referral to Neurology:

****** Include a 1-page summary of the patient's exams, workup, history, and results. If this is not included, the referral will be sent back.***

☐ Epilepsy/ Seizure: What is the date of last seizure:

_____

☐ Multiple Sclerosis (MS)

- Confirmed diagnosis — Yes No
- Are MRI images and interpretations available in Epic? — Yes No
  If not, please send to Neurology
- Are records available in Epic? — Yes No
  If not, please send to Neurology

☐ Adult Neuromuscular:

- Does the patient have muscle cramps, weakness, or myalgias? — Yes No
- Does the patient have general fatigue? — Yes No
- Does the patient have new or worsening numbness? — Yes No
- Has the patient had an EMG? — Yes No
  (Consider ordering if patient has numbness)

GUNDERSEN HEALTH SYSTEM®

Gundersen Lutheran Medical Center, Inc | Gundersen Clinic, Ltd
1900 South Avenue | La Crosse, WI 54601 Mailstop:EB3-001
(608) 775-9000 | Neurosciences Fax number: (608) 775-5263

☐ Autonomic Disorders/Dysautonomia

☐ POTS ☐ Orthostatic Intolerance ☐ Syncope

☐ Orthostatic Hypotension ☐ Multiple System Atrophy

☐ Gastroparesis/Constipation ☐ Hyper/Hypo-Hirdrosis

☐ Other Dysautonomia

Please include results of orthostatic vital signs withreferral. Patients referred for syncope require prior cardiology evaluation.

In this consult for a 2nd opinion? ☐ Yes ☐ No

Has the patient had prior autonomic testing? (please include) ☐ Yes ☐ No

Has the patient had prior cardiology evaluation? (please include) ☐ Yes ☐ No

☐ Stroke/TIA

Is the patient being discharged from a hospital, emergency room, or urgent care?

☐ Yes - place Consult to Stroke Clinic for hospital/ER/urgent care follow-up

☐ No _____

☐ Movement Disorder

- Describe Symptoms _____

  _____

- Referring provider has validated symptoms are not medication related Yes No

  **If not, the patient should be seen by PCP

☐ Headache

Does the patient have migrainous symptoms?

☐ Yes ☐ No _____

Which medications have been tried?

_____

How often are they having migraines?

_____

How many migraines days are they having a month?

_____

Is the patient a special population (pregnancy, treated for cancer, immunocompromised, cluster headache, facial pain/trigeminal neuralgia)

☐ Yes ☐ No _____

Has the patient had a recent TBI?

☐ Yes - place a consult to Phys Med & Rehab ☐ No _____

In this a consult for Papilledema/Idiopathic Intracranial Hypertension (IIH)/Pseudotumor?

☐ Yes - please call Neurology on-call (608-782-7300, ask for on-call Adult Neurologist) due to potentially emergent nature of this disease

☐ No _____

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☐ Memory Concerns

- I have worked up the patient's cognitive concerns, including cognitive testing. MoCA required.

  Yes No, please specify:_____
  _____

- REQUIRED: B12, Vit D, TSH+/- Free T4, Na, AST, ALT, CBC/Hg, glucose, creatinine.

  Yes No, please specify:_____
  _____

- REQUIRED IMAGING: MRI or non-contrast CT of Head must be completed within the last 5 years. If imaging is not completed, the consult will be denied.

  Yes No, please specify:_____
  _____

- I have screened for and treated secondary causes (mood, drugs, ETOH, sleep, OSA, etc).

  Yes No, please specify:_____
  _____

☐ Pediatric Neurology

☐ Other Neurological Concerns

Please include details and described concerns using the summary page.

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