Cleveland Clinic

# NEUROLOGICAL INSTITUTE PHYSICIAN REFERRAL

**Preferred methods of communication**

Supply us with your patient's medical records in one of these ways:

Fax: 216.636.2596
Phone: 216.445.8455

Or mail to:
Cleveland Clinic, T1-203
9500 Euclid Ave.
Cleveland, OH 44195

Asterisk (*) indicates a required field needed to complete the referral request.

| | | | |
|---|---|---|---|
| Date | Type of Reservation ☐ Regular ☐ Urgent (as soon as possible) | | |
| Purpose ☐ Diagnosis ☐ Surgery ☐ Other (specify) | | | |
| Please Identify the Subspecialist to be Seen* | ☐ Behavioral Health/Psychiatry<br>☐ Brain Health/Dementia<br>☐ Brain Tumor/Neuro-Oncology<br>☐ Cerebrovascular<br>☐ Epilepsy | ☐ Headache & Facial Pain<br>☐ Movement Disorders<br>☐ Multiple Sclerosis<br>☐ Neuromuscular<br>☐ Pediatric Neurosciences | ☐ Physical Medicine & Rehabilitation<br>☐ Sleep Disorders<br>☐ Spine Health |
| Reason for Referral (diagnosis or symptoms; DO NOT enter ICD codes here): | | | |
| Are you requesting a specific provider? ☐ Yes ☐ No | If yes, please indicate | | |
| Patient Name* | | DOB | |
| Street Address | City | State | Zip code |
| Patient Phone* | | | |
| Insurance Name/Plan:<br>Subscriber DOB: | Subscriber Name:<br>ID#: | Group#: | |
| **Please send copies of insurance cards for verification purposes** | | | |
| Referring Physician* | | Phone* | |
| Referring Physician Preferred Fax # | Referring Physician Practice Name | | |
| Past Test Results and Visit Notes Related to this Referral (if available, please check and submit the records) | ☐ Angiogram<br>☐ CT<br>☐ CTA<br>☐ Echo<br>☐ EEG<br>☐ EKG<br>☐ EMG<br>☐ HSAT | ☐ Ictal SPECT<br>☐ MEG<br>☐ MRI<br>☐ PET<br>☐ PSG<br>☐ Rhythm monitoring<br>☐ Ultrasound | ☐ Significant labs: lipid panel, HbA1c, hypercoag panels, LP studies<br>☐ Neurological office visit notes (including H&P)<br>☐ Previous neurosurgical records (if referral is to surgery)<br>☐ Hospital discharge summary<br>☐ Other |