THE University of Vermont Children's Hospital

Pediatric Neurology New Patient Intake Form

Phone: 802-847-4589 Fax: 802-847-8742

Patient Name: _____ DOB: _____ Sex: _____

Address: _____

Parent/Guardian's Name: _____

Relation to patient: _____

Phone #: (H): _____(W): _____(M): _____

Reason for Referral: _____

☐ Migraine/Headache

☐ Epilepsy/Seizure Disorder

☐ Developmental or Motor Delay

☐ Movement Disorder

☐ Neuromuscular Disorder

☐ Other (please specify): _____

Please specify if/where/when the following were completed:

☐ Imaging: _____

☐ EEG: _____

☐ Labs: _____

☐ Other: _____

Please state if, and why, this referral is urgent: _____

_____

Does the patient's family know about this referral? Y N

Has the patient ever been seen by a neurologist? Y N **Please forward <u>all</u> records & imaging**

If so, where/when? _____

_____

Referring Provider: _____

Phone #: _____ Fax #: _____

Patient's PCP (if different than Referring Provider): _____

Insurance information:

Primary Insurance Co: _____ Secondary Insurance Co: _____

Policy #: _____ Policy #: _____

Phone #:_____ Phone #: _____

<u>Please fax relevant notes/labs/reports</u> to **802-847-8742**, with this form as the cover sheet, "**Attn: Pedi Neurology**". **<u>Please send relevant imaging</u>** to the UVM Medical Center, electronically if possible, or mail on CD to: **University of Vermont Medical Center**
Attn: Pediatric Neurology
111 Colchester Ave.
Burlington, VT 05401
ph: 802-847-4589