THE University of Vermont MEDICAL CENTER

Neurology New Patient Intake form

Patient Name: _____

Patient DOB: _____

Patient Address: _____

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

Alternative Contact Name: _____Alternative Contact Number: _____

Reason for Referral:

_____

_____

- O General (specify clinical issue) _____
- O Botulinum toxin clinic (blepharospasm, dystonia, migraine, spasticity,
- O Migraine/headache
- O Movement Disorder (eg Parkinson's disease, tremor, Huntington's, involuntary movements)
- O Multiple Sclerosis
  - o Spasticity
- O Neuromuscular (eg neuropathy, muscle disease, ALS)
- O Stroke / neurovascular
- O Other (please specify) _____

Is referral for consult only? _____ Or ongoing care? _____
Is the patient under the care of a neurologist? Y N
Has the patient already seen a neurologist at UVMMC in the past? Y N When ? _____
Referring Provider: _____ Neurologist? _____Yes _____No
Referring Provider Address: _____
Referring Provider Phone: _____

PCP (if different than Referring Provider): _____
PCP Address: _____
PCP Phone: _____

Insurance information:
Is this visit related to a work place injury? Y N
Primary Insurance Co: _____ Secondary Insurance Co: _____
Policy #: _____ Policy #: _____
Phone: _____ Phone: _____

Please fax pertinent notes and imaging to (802) 847-2461. If possible, please have images pushed to UVMMC system electronically. Questions?, please call us at (802) 847-4589.

PLEASE CHECK APPROPRIATE BOX BELOW:
Pertinent notes/images have been sent via ❑ fax ❑ electronically