UNC DEPARTMENT OF NEUROLOGY

→Date of Request _____

UNC Child Neurology Referral Form

Please fill out as much of this form as possible to facilitate the consultative process

Please note that we do not offer consultative services for concussion, learning difficulties, behavior problems, ADHD or autism (except if there is a concern about comorbid epilepsy).

Please Print Clearly

PATIENT INFORMATION:

Name _____ Date of Birth _____

Address_____ City _____ State ____ ZIP _____

Preferred Phone No. _____ Secondary Phone No. _____

Insurance: _____ Guarantor/Parent _____

REFERRING CARE-PROVIDER INFORMATION:

Referring Physician: _____

Phone # _____ Fax # _____

PERTINENT MEDICAL HISTORY (REQUIRED): This is essential for efficient triage. **Date of Onset**: _____
(Referral **will not be reviewed** if question is not specified)

→ * Question you would like answered: _____ *

For example: treatment of headaches, management of 3 recent seizures, infant with developmental delay etc.

Additional Information: _____

For example comorbid conditions that may make evaluation more urgent

URGENCY:

	Emergent – please send to ER
☐	Routine
☐	Medically urgent – as soon as possible in the next few weeks
☐	Socially Urgent – please state reason and time frame desired: _____

Medically urgent? – Requesting to as soon as possible in **the next few days** - **Call on-call neurologist to discuss 919-966-4005**

Please Fax this form and all pertinent records to: 984-974-5437

Please include relevant PCP visits, prior neurology visits, MRI and EEG reports