UCLA Department of Neurology
Request for Outpatient Consultation

Phone: (310) 794-1195

Fax: (310) 794-7491

To be completed by physicians/clinic staff

Patient Information

(UCLA Referring-please place label here)

Name: Last_____
First _____
(Please Print)
UCLA Registration# _____ **DOB:** _____

Cell (_____) _____

Address: _____
City:_____ **State:**_____ **Zip:** _____

To

General Neurology ☐ **(Standard neurologic care for all conditions), or Subspecialty Clinic:**

☐ Ataxia	☐ Headache	☐ Neurobehavior
☐ Dementia	☐ Epilepsy	☐ Neuro Oncology
☐ Sleep	☐ Stroke	☐ Multiple Sclerosis
☐ Autonomic disorders	☐ Neuro Otology	☐ Huntington's Disease
☐ Neuroinfectious Disease/NeuroAIDS	☐ Neuro-Rehabilitation	☐ Movement Disorder
☐ Neuromuscular:		
☐ ALS & other motor neuron diseases	☐ Adult neuromuscular disease	☐ Pediatric neuromuscular diseases

or
Neurologist's Name _____

NOTE:
If the requested neurologist is unavailable, the patient will be seen by an alternative neurologist from the same subspecialty program. If you would prefer that no appointment be made if the requested neurologist is unavailable, please check here ☐

Reason for Consult and Urgency

Reason For Consultation:

Presumptive Diagnosis: _____

Second Opinion? ☐**YES** ☐**NO**

Appointment Requested: ☐ **Next Available** ☐ **Within 2 weeks** ☐ **Within 1 week** ☐ **Other** _____

If patient needs to be seen sooner than next available appointment, please indicate why:_____

If specific studies are available please indicate below and request patient to hand deliver films/outside tests/notes :

☐ **MRI** ☐ **CT** ☐ **EEG** ☐ **EMG/NCV** ☐ **Sleep Study** ☐ **Clinic Notes** ☐ **Other**_____

From

Referring Physician:_____ **Office Name:**_____
Last (Please Print) First

Office Contact:_____ **Phone# (_____) :**_____

Fax#: (____) _____ **E-Mail Address:** _____

PCP (If different from Referring)

Physician Name:_____ **Office Name:**_____
Last (Please Print) First

Office Contact:_____ **Phone# (_____) :**_____

Fax#: (____) _____ **E-Mail Address:** _____

Patient's Other Contact Information (if applicable)

Name:_____

Telephone: Home (_____) _____ **Work (_____)** _____ **Cell (_____)** _____

Insurance Information

Insurance:_____ ☐**HMO** ☐**PPO** ☐**POS** ☐**Traditional** ☐**Medicare** ☐**None**

Medicaid: ☐**HMO** ☐**Other** **Medicaid Insurance Plan:**_____

Auto Accident? ☐**Y** ☐**N** **Date of Injury** _____ **Work Comp?** ☐**Y** ☐**N** **Date of Injury**_____

Requesting Physician

Physician Signature:

_____
(Signature) (Date)

Once you have faxed the form, please ask patient to call us to schedule an appointment at: (310) 794-1195. For clarification, please call (310) 794-1195.