LOMA LINDA UNIVERSITY
HEALTH CARE

Referral Form
Pediatric Neurology

Scheduling Line: 909-651-1810
Fax: 909-651-4257

PLEASE NOTE: If a **Pediatric Neurosurgery** consultation is requested, please do not use this form. Call 909-558-6388.

Patient Information	
Does this patient live with someone other than the legal guardian? □ No □ Yes, relationship: _____	
Patient Name:	Date of Birth:
Parent/Guardian:	Parent/Guardian Cell Phone:
Insurance:	Home Phone:

1. Please select the type of referral: □ STAT □ Urgent □ Routine

If Stat or Urgent, please call our doctor-to-doctor line (909) 558-0099

2. Is this referral for a second opinion? □ **No** □ **Yes**

3. Please describe the patient's chief complaint and *include onset and frequency:*_____

_____

4. What is the key question you want us to answer? _____

_____

Reason for referral:

□ **General Neurology**	Includes but not limited to: concussion or traumatic brain injury, micro/macrocephaly, cerebral palsy, tic disorder, abnormal movements, tremor
□ **Botox**	
□ **First Seizure**	For first time unprovoked, **non-febrile seizure**
□ **Seizures (Other)**	For seizures, seizure-like activity, or epilepsy
□ **Intractable Epilepsy**	Tried 2 or more medications and still experiencing seizures; epilepsy surgery evaluation; evaluation for ketogenic diet or vagal nerve stimulator
□ **Headaches or Migraines**	
□ **Neurodevelopmental Disorders** For neuropsychological testing, please refer to school district or neuropsychology	Autism spectrum disorder, developmental delay, intellectual disability.
□ **Neuromuscular Disorders**	Spinal muscular atrophy; muscular dystrophy; peripheral neuropathy, myasthenia gravis, myotonia
□ **Sleep Disorders**	Obstructive or central sleep apnea, insomnia, restless leg syndrome, period limb movement disorders, parasomnias, disorders of excessive sleepiness
□ **Other**	Please explain:

To optimize appointment scheduling, please provide the following by FAX to 909-651-4257

- This completed form
- Medical records related to the chief complaint
- Prior neurology records including EEG, CT, or MRI result
- A copy of the patient's insurance card
- If authorization is required, was authorization submitted? □ **Yes** □ **No** □ **Not Applicable**

Referring Provider Name: Address: City, State, Zip: Phone: Fax:	OR Provider Stamp

***Please notify the patient to call our Scheduling Line to make an appointment: 909-651-1810.**