Childrens Hospital Los Angeles - Division of Neurology
(323) 361-2471 - Fax: (323) 361-1109

NEUROLOGY CONSULTATION INTAKE FORM

Please provide the following information for consultation screening. Answer all applicable items and forward recent test results such as: EEG, Video EEG, CT Scan, MRI, and Lab Reports. FOR A SECOND OPINION, PLEASE ATTACH ALL PRIOR NEUROLOGICAL REPORTS. IF THIS CONSULTATION IS URGENT, PLEASE PROVIDE DETAILS OF NEED ON A SEPARATE SHEET OF PAPER. PLEASE BE SPECIFIC.

Date:_________________

PLEASE PRINT OR WRITE CLEARLY:

Patient Name:____D.O.B._____________

Primary M.D.:____

Address: ____

PMD Phone:(____)__________________________PMD Fax:(_____) _____________________

Referring MD (if different from Primary MD)____

Reason for Consultation: Please be specific. If seizure: onset, febrile or afebrile, current frequency, type.

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TO BE SEEN BY DR. SANGER IN THE MOVEMENT DISORDERS CLINIC.

☐ Febrile Seizure Only ☐ EEG Needed ☐ EEG already done, report attached

☐ Child on AED's (Specify dose, drugs):

____

Development:____

____

Other Neurological Condition:____

____

Relevant Past Medical History:____

____

____

Current Medications: ____

Parent Name:______________________________ Other Contact:_______________________

Phone-Day (_____)__________________ Night (______) ____________________________

Insurance:_____________________________ Authorization # _________________________

Medi-Cal #________________Issue Date:________________HMO Insurance:____________

NOTE: ILLEGIBLE FORMS CANNOT BE PROCESSED.