

\**for Physician use only*

CSF EVALUATION REFERRAL FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD Code:\_\_\_\_\_\_\_\_\_\_\_\_ Brief Description of Problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last MRI Brain with contrast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must be within 6 months)

**PRE-CONSULTATION REQUIREMENTS:**

* Referral (preferably from a Neurologist or Headache Specialist)
* MRI of the brain **with contrast** performed within the last 6 months- We MUST have images on a CD mailed to our office, the report is not sufficient. **Imaging can be shared electronically through powershare**
* Copies of clinic notes and imaging reports related to your symptoms (Can be faxed to 919-681-9914)
* Copy of front and back of insurance card
* CT Myelogram/MRI spine: (not required, but must submit if performed)

Note: Incomplete referral form will cause a delay in patient consultation