



QR Code iowaneurologyandsleep.com

REFERRAL FORM

Patient Name _____ DOB _____

Address _____ Phone _____

Diagnosis/Chief Complaint _____ Insurance _____

Referring Provider _____ Phone _____

☐ Neurology Consult

Reason for Consult _____

☐ EMG/Nerve Conduction Extremities _____ Weight _____

****PATIENT MUST BE ABLE TO GET ON AND OFF EXAM TABLE WITHOUT ASSISTANCE****

****OUR EQUIPMENT HAS A WEIGHT LIMIT OF 325 POUNDS****

Is this work comp? ☐ YES ☐ NO (If yes, then work comp information must be sent with form.)

Please include the following items: (**WE WILL NOT SCHEDULE UNTIL ALL INFORMATION IS RECEIVED.**)

- Patient demographics and insurance card
 - Hospital/ER notes
 - MRI/CT reports (send disc or push images to SEIRMC)
 - Clinical notes
 - Lab test results
 - Medication list
 - Previous neurology notes
 - Prior EEG or EMG results

*****PLEASE COMPLETE FORM AND FAX ALL INFORMATION TO 844.676.1363*****