

# New Patient Referral

Date: \_\_\_ / \_\_\_ / \_\_\_

Time: \_\_\_\_\_

Initials \_\_\_\_\_

Name: \_\_\_\_\_ Sex: M / F SS# \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Group Home? Y or N \_\_\_\_\_

Phone: Home: (\_\_\_\_) Work: (\_\_\_\_)

DOB: \_\_\_ / \_\_\_ / \_\_\_ Phone: C / H / W (\_\_\_\_)

Legal Guardian: \_\_\_\_\_ Phone: C / H / W (\_\_\_\_)

Relationship to Patient: \_\_\_\_\_ Phone: C / H / W (\_\_\_\_)

Father: \_\_\_\_\_ Phone: C / H / W (\_\_\_\_)

Mother: \_\_\_\_\_ Phone: C / H / W (\_\_\_\_)

Referred by: \_\_\_\_\_ Referral made by: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) Phone: (\_\_\_\_)

Primary M.D. \_\_\_\_\_ Phone: (\_\_\_\_)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance 1 \_\_\_\_\_ Insurance 2 \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

SS #: \_\_\_\_\_ SS #: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Claim #: \_\_\_\_\_ Grp: \_\_\_\_\_ Claim #: \_\_\_\_\_ Grp: \_\_\_\_\_

Phone: (\_\_\_\_) Phone: (\_\_\_\_)

**Appointment:** \_\_\_\_\_ Inpatient \_\_\_\_\_ Lipschultz \_\_\_\_\_ Outpatient \_\_\_\_\_ Appointment Canceled (file)

Date: \_\_\_ / \_\_\_ / \_\_\_ Reason for Referral: \_\_\_\_\_

Notes: \_\_\_\_\_

Onset: \_\_\_\_\_

Seizure Type: \_\_\_\_\_

Frequency: \_\_\_\_\_

Medications: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Medical History: \_\_\_\_\_

Psycho-social: \_\_\_\_\_

## EDUCATION WITH NURSE

- None
- 1 Hour Before Clinic
- 30 Minutes
  - Before Clinic
  - After Clinic