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Heal Your Brain ***With Your Mind***

Neurology / Sleep Disorders Referral Form

FAX: (808) 748 - 2920 | Phone: (808) 294-3332

Secure Email: Referral@HonoluluNeuroscienceClinic.com

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ________ Sex: M ☐ F ☐

Address: ____

Home Phone: ______________ Work Phone: ____________ Cell Phone: ________________

Insurance Provider: __________________________ Subscriber Number: ________________

Secondary Insurance: ________________________ Subscriber Number: ________________

REFERRING DOCTOR INFORMATION

Name: ______________________________ Contact Person: ____________________

Address: ______________________________ Email: ________________________

Phone Number: ________ Fax Number: __________________________

Signature: ______________________________ Date: __________________________

PCP information if different than referring doctor

PCP: ______________________________________ FAXNumber: ____________________

Address: ___________________________________ Email: _________________________

REASON FOR REFERRAL

ICD 10 CODES: ____

PLEASE MARK ALL THAT APPLY

(__) Cognitive decline, attention, concentration difficulties
(__) Visual disturbances, diplopia,
(__) OSA, Sleep disturbances, narcolepsy, fatigue, insomnia
(__) Other: ____________________________
(__) Tremor, weakness, muscle atrophy
(__) Pain associated with headaches, migraines, neck/back pain
(__) Seizures / Epilepsy / involuntary movements / fits

AND (__) Diet of Hope (metabolic disorders with neurological disorder from above)

Please send appropriate referral notes, recent lab work, prior sleep studies, recent ER visit MRI / CT / XR's

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