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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: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Primary Insurance: _____ Subscriber Number: _____

Secondary Insurance: _____ Subscriber Number: _____

REFERRING DOCTOR INFORMATION

Name: _____ Contact Person: _____

Address: _____

Email: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

PCP information (if different than referring doctor):

PCP: _____ Phone Number: _____

Fax Number: _____ Email: _____

REASON FOR REFERRAL

ICD 10 CODES: _____

PLEASE MARK ALL THAT APPLY

- | | |
|---|---|
| <input type="checkbox"/> Cognitive decline, attention, concentration difficulties | <input type="checkbox"/> Tremor, weakness, muscle atrophy |
| <input type="checkbox"/> Visual disturbances, diplopia, | <input type="checkbox"/> Pain associated with headaches, migraines, neck/ back pain |
| <input type="checkbox"/> OSA, Sleep disturbances, narcolepsy, fatigue, insomnia | <input type="checkbox"/> Seizures / Epilepsy / involuntary movements / fits |
| <input type="checkbox"/> Other: _____ | |

AND 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