

NEURO CONSULTATION REQUEST

Fax completed referral information to **269.343.9555**. Please include any test results to expedite referral process.

An appointment notification will be provided to you within 48 hours of referral and document receipt. We will also notify your patient of their appointment time and date.

If you are using the electronic process, please scan support documents and e-mail to brainspine@borgess.com or fax support information to 269.343.9555

Borgess Neurology
1541 Gull Road, Suite 200
Kalamazoo, MI 49048
269.381.7380

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Todd Helgeson, PA-C
Abby Rogers, PA-C
Connie Van Es, NP-C

Referring Physician	Today's Date
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Contact Name	Phone	Fax
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PATIENT INFORMATION

Patient Name (Last)		(First)	
Address			D.O.B.
City	State	ZIP	SS# XXX - XX -
Home Phone	Work Phone		Cell Phone

Insurance Please provide photocopy of front and back of card

Family Physician

CLINICAL INFORMATION

Diagnosis for Referral	Duration of Symptoms																																			
<table border="1" style="width:100%"> <tr> <th style="width:30%">Neurological Deficits</th> <th style="width:30%">Studies</th> <th style="width:30%">Location</th> <th style="width:30%">Previous Conservative Treatment</th> <th style="width:30%">Location</th> </tr> <tr> <td><input type="checkbox"/> Loss of Bowel / Bladder</td> <td><input type="checkbox"/> MRI</td> <td>_____</td> <td><input type="checkbox"/> PT</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Foot Drop</td> <td><input type="checkbox"/> CT Scans</td> <td>_____</td> <td><input type="checkbox"/> Injections</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Weakness</td> <td><input type="checkbox"/> EMG</td> <td>_____</td> <td><input type="checkbox"/> Pain Clinic</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Sensory Loss / Numbness</td> <td><input type="checkbox"/> X-Ray</td> <td>_____</td> <td><input type="checkbox"/> Chiropractic</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Bone Scan</td> <td>_____</td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> <td></td> <td></td> </tr> </table>	Neurological Deficits	Studies	Location	Previous Conservative Treatment	Location	<input type="checkbox"/> Loss of Bowel / Bladder	<input type="checkbox"/> MRI	_____	<input type="checkbox"/> PT	_____	<input type="checkbox"/> Foot Drop	<input type="checkbox"/> CT Scans	_____	<input type="checkbox"/> Injections	_____	<input type="checkbox"/> Weakness	<input type="checkbox"/> EMG	_____	<input type="checkbox"/> Pain Clinic	_____	<input type="checkbox"/> Sensory Loss / Numbness	<input type="checkbox"/> X-Ray	_____	<input type="checkbox"/> Chiropractic	_____		<input type="checkbox"/> Bone Scan	_____	<input type="checkbox"/> Other	_____		<input type="checkbox"/> Other	_____			
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Thank you for your referral!