New Patient Referral/ Physician Order for Neuroimmunology

Boston Children's Hospital
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PLEASE BE ADVISED

- Please fill out ALL fields and fax to 617-730-0285
- Please ensure that the form is signed and dated by the ordering clinician (bottom of page).
- For all questions, please call the Neuroimmunology Center at 857-218-4794

Patient information

Last name: _____

First name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ◉ Home ○ Work ○ Cell

Other phone: _____ ◉ Home ○ Work ○ Cell

Other phone: _____ ◉ Home ○ Work ○ Cell

Referring physician information

Physician name: _____

Physician specialty: _____

Practice name: _____

Physician email: _____

Physician phone: _____

Practice fax number: _____

Practice address: _____

_____

Requested appointments, in addition to neuroimmunology

Consult 1: _____

Consult 2: _____

Other: _____

Items to include

- Demographic sheet with insurance information
- Pertinent notes (admission, discharge, neurology, ophthalmology, rheumatology consults/visits etc), lab results, imaging reports
- Images sent electronically or mailed via CS

or mail to the attention of:

Neuroimmunology Center
Department of Neurology, Fegan 11
300 Longwood Ave.
Boston, MA 02115

Requested timeframe schedule

_____

Please understand that appointments will be scheduled based on availability, as well as triaged clinical severity.

If this form is not fully completed, this may delay patient care.