PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT

Children's Hospital Neurology Foundation

Your child's neurologist will send a letter from today's visit to the practitioner who referred you to us. Others may also need a copy of that letter. In order to make sure that everyone who needs to know about your child's neurological care gets a copy of today's letter, please fill in below the names and complete addresses **of everyone who should receive a copy** (other clinicians, therapists, schools, yourself, etc.). Please sign and date the bottom of this form.

Referring Clinician ____
Street Address: ____
City, State, Zip: ____

Others:

Name: ____
Street Address: ____
City, State, Zip: ____

Name: ____
Street Address: ____
City, State, Zip: ____

Name: ____
Street Address: ____
City, State, Zip: ____

In order to protect the privacy of your child's medical information, please list **individuals who may not obtain a copy** of the results of your child's neurological examination (schools, other parent/guardian, physicians, etc.).

Name: ____
Street Address: ____
City, State, Zip: ____

Name: ____
Street Address: ____
City, State, Zip: ____

Parent/Guardian's signature:	**Parent/Guardian's full name:**	**Date:**
________________________	________________________	__________