225 Smith Ave N., Suite 201 Saint Paul, MN 55102 (651) 241-5290

Initial Patient Contact/Referral Form

Date: ____/____/_____
Initials: _____
Interp: _____
Language: _____

Name: _____ Sex: M / F SS# _____
Address: _____ Group Home? Y or N _____
City: _____ State: _____ Zip: _____ Foster Home? Y or N _____
Phone: Home: (_____) _____ Work: (_____) _____
Email address for patient / parent or guardian: _____
DOB: _____/_____/_____ Phone: C / H / W (_____) _____
Legal Guardian: _____ Phone: C / H / W (_____) _____
Contact Person: _____ Phone: C / H / W (_____) _____
Father/Spouse: _____ DOB: _____ Phone: C / H / W (_____) _____
Mother/Spouse: _____ DOB: _____ Phone: C / H / W (_____) _____

Referred by: _____ Referral made by: _____
Address: _____ Address: _____
_____ _____
_____ Phone: (_____) _____
Phone: (_____) _____ Fax: (_____) _____

Primary M.D. _____ Phone: (_____) _____
Address: _____ Fax: (_____) _____
City: _____ State: ____ Zip: _____ Pharmacy: _____

Insurance 1 _____ Insurance 2 _____
Address: _____ Address: _____
Policy Holder: _____ Policy Holder: _____
Relation to Patient: _____ Relation to Patient: _____
Benies Date: _____ Benies Date: _____
Eff. Date: _____ Eff. Date: _____
ID #: _____ Grp: _____ ID #: _____ Grp: _____
Phone: (_____) _____ Phone: (_____) _____

Appointment: _____ Inpatient _____ Lipschultz _____ Outpatient _____ Appointment Canceled (file)

Date: ____/____/_____ Reason for Referral: _____

_____

Notes: _____

_____

_____

Onset: _____

Seizure Type: _____

Frequency: _____

Medications: _____

DATE PACKET SENT:

_____

DATE PACKET DUE BACK:

_____

CT / MRI / EEG: _____

Medical History: _____

_____

Psychosocial: _____

Physician treating you for seizures:_____

_____

Phone #:_____

Dates of care:_____

Primary physician:_____

Phone #:_____

Dates of care:_____

Other physicians: _____

Phone #:_____

Dates of care:_____

Other physicians: _____

Phone #:_____

Dates of care:_____

Hospitalizations:_____

_____

Phone #:_____

Dates of care:_____

Additional Hospitalizations:_____

_____

Phone #:_____

Dates of care:_____

CT scan: YES / NO

Location:_____

_____

Phone #:_____

Dates of care:_____

MRI scan: YES / NO

Location:_____

_____

Phone #:_____

Dates of care:_____

EEGs: YES / NO

Location:_____

_____

Phone #:_____

Dates of care:_____