WVUMedicine

Comprehensive Movement Disorders Referral

PHONE: **304-598-6127** FAX: **304-598-6442** **PO Box 9180, Morgantown, WV 26506-9180**

Date of Referral: _____/_____/_____

Referring Physician: _____ Contact Person: _____

Phone #: _____ Fax #: _____

Address: _____

Email Address: _____

PROVIDER INFORMATION

Please indicate a preferred provider, if known:

- ☐ **Ann Murray**, MD, Neurology
- ☐ **Richa Tripathi**, MD, Neurology
- ☐ **Nicholas Brandmeir**, MD, Neurosurgery
- ☐ **Milind Deogaonkar**, MD, Neurosurgery
- ☐ **Ali Rezai**, MD, Neurosurgery
- ☐ **Peter Konrad**, MD, Neurosurgery

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

DOB: _____/_____/_____ Social Security #: _____

Address: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Insurance Co. Name: _____

Policy ID #: _____

Subscriber's Name: _____

PATIENT DOCUMENTS

☐ **WVHIN** ☐ **EPIC**

If not, FAX or MAIL the following:

- ☐ **Diagnosis and symptoms**
- ☐ **Radiographic studies completed with date**
- ☐ **Radiology reports and/or lab results**
- ☐ **Recent progress notes and any other pertinent information related to diagnonsis**
- ☐ **Copy of insurance/Rx card**

Diagnosis:

- ☐ **Parkinson's disease**
- ☐ **Essential tremor**
- ☐ **Cervical dystonia**
- ☐ **Unclear tremor**
- ☐ **Ataxia**
- ☐ **Tic disorder**
- ☐ **Chorea**
- ☐ **Huntington's disease**
- ☐ **Myoclonus**

Has this patient been seen by a neurologist for the same or similar problem before?

☐ **YES** ☐ **NO**

Please have patient hand carry pertinent radiographic studies on CD.