OSF HEALTHCARE
Illinois Neurological Institute

NEUROLOGY REFERRAL REQUEST FORM

INI Scheduling Phone 877-464-6670 | Fax 877-464-6806

This form reflects a new INI outpatient referral process, whereby cases are triaged based on clinical features supplied by a referring provider rather than requested urgency. Please confirm that neuroimaging has been sent to OSF PACS and that prior neurology notes, EMGs, EEGs, and other relevant reports are forwarded for review to ensure timely triage. Acute focal deficits and other neurological emergencies should be directed to the ED. If a patient must be seen within three days, the referring provider may call the Physician Access Line 309-655-7257 to discuss with a provider. ***If patient insurance requires prior authorization, the referring provider must obtain this prior to INI scheduling.***

Patient Name: ______________________________ **DOB:** _________ **Phone:** __________________ **Gender:** ____

Address: ____ **City:** _________________ **State:** ____ **Zip:** __________

Insurance: _____________________________ **Insur. ID:** _____________________ **Group#:** _________________

Referring Provider: __________________________ **Phone:** ____________________ **Fax:** ____________________

Location (select one):

__ INI Bloomington __ INI Evergreen Park __ INI Galesburg __ INI Peoria Penn __ INI Rockford

Reason for Referral (failure to specify will delay triage):

__ Headache
__ Paresthesia or neuropathy
__ Weakness (incl. ALS, MG)
__ Seizure or epilepsy
__ Tremor or movement disorder
__ Ataxia or gait dysfunction
__ Cognitive changes
__ Dizziness or (pre)syncope
__ Vision changes
__ Stroke or TIA
__ MS or neuroimmunology
__ Verbal dysfunction
__ Abnormal imaging
__ EMG & NCS
__ Other ____________

Clinical features (select one per line):

1. Acute onset with associated focal deficit, ascending weakness, or incontinence: __ Yes __ No
   (If yes, please consider ED evaluation rather than outpatient neurology referral)
2. New headache in pt >50 yrs old, with malignancy, HIV, etc. or triggered by valsalva, cough: __ Yes __ No
   (If yes, please consider MRI brain and/or head angiogram in addition to or instead of this referral)
3. Associated diplopia, dysphagia, dyspnea, motor neuron signs, or concern for ALS: __ Yes __ No
   (If yes, consider PFTs and/or speech therapy in addition to this referral)
4. Is patient pregnant: __ Yes __ No
   (OSF neurologists will generally not prescribe medications for headache during pregnancy.)
5. Temporal nature: __ Variable __ Episodic __ Persistent __ Progressive
6. Location: __ Distal __ Generalized __ Proximal __ Multifocal __ Left __ Right __ Holocephalic
7. Workup conducted for this problem: ____
8. Current or prior medications and treatments for this issue: ____________________________
9. Related to a concussion or TBI: __ Or Workers Compensation: __ Or neither: __
10. Second opinion request: __ Or transition from prior neurologist: __ Or neither: __

TBI and workers comp cases may require non-OSF subspecialty input. Please consider vestibular rehab, ENT (esp. neurotology), and/or audiology for peripheral dizziness or vertigo, cardiovascular investigations (e.g. TTE, tilt table) for lightheadedness or syncope, neurosurgery for structural brain pathology (e.g. tumors, cysts, Chiari, hydrocephalus), sleep medicine for RLS and other sleep disorders, Chicago subspecialist referral for autonomic issues (e.g. POTS), and speech therapy for primary speech or swallowing concerns.