Cleveland Clinic

NEUROLOGICAL INSTITUTE PHYSICIAN REFERRAL

Preferred methods of communication

Supply us with your patient's medical records in one of these ways:

FAX 216.636.2596

CALL 216.445.8455

Or mail to:
Cleveland Clinic, T1-203
9500 Euclid Ave.
Cleveland, OH 44195

Asterisk (*) indicates a required field needed to complete the referral request.

Date	Type of Reservation ☐ Regular ☐ Urgent (as soon as possible)		
Purpose ☐ Diagnosis ☐ Surgery ☐ Other (specify)			
Please Identify the Subspecialist to be Seen*	☐ Brain Health/Dementia ☐ Brain Tumor/Neuro-Oncology ☐ Cerebrovascular ☐ Comprehensive Pain Recovery ☐ Epilepsy	☐ Headache & Facial Pain ☐ Movement Disorders ☐ Multiple Sclerosis ☐ Neuromuscular ☐ Pain Medicine	☐ Pediatric Neurosciences ☐ Physical Medicine & Rehabilitation ☐ Psychiatry & Psychology ☐ Sleep Disorders ☐ Spine Health
Reason for Referral (diagnosis or symptoms; DO NOT enter ICD codes here):			
Are you requesting a specific provider? ☐ Yes ☐ No	If yes, please indicate		
Patient Name*		DOB	
Street Address	City	State	Zip code
Patient Phone*			
Insurance Name/Plan: Subscriber DOB:	Subscriber Name: ID#:	Group#:	
Please send copies of insurance cards for verification purposes			
Referring Physician*		Phone*	
Referring Physician Preferred Fax #	Referring Physician Practice Name		
Past Test Results and Visit Notes Related to this Referral (if available, please check and submit the records)	☐ Angiogram ☐ CT ☐ CTA ☐ Echo ☐ EEG ☐ EKG ☐ EMG ☐ HSAT	☐ Ictal SPECT ☐ MEG ☐ MRI ☐ PET ☐ PSG ☐ Rhythm monitoring ☐ Ultrasound	☐ Significant labs: lipid panel, HbA1c, hypercoag panels, LP studies ☐ Neurological office visit notes (including H&P) ☐ Previous neurosurgical records (if referral is to surgery) ☐ Hospital discharge summary ☐ Other