

Office use only	Name: _____
	MRN: _____
	Visit #: _____

Thank you for referring your patient to the Division of Neurological Surgery at the University of Missouri. In order to expedite your patient's care we must this completed referral request as well as copies of the following before an appointment can be made:

- |   |   |
|---|---|
| <input type="checkbox"/> Patient Demographic Information                        | <input type="checkbox"/> Written Report of MRI or CT that has been done <u>within the past 6 months</u> |
| <input type="checkbox"/> Copy of the Front and Back of Patient's Insurance Card | <input type="checkbox"/> Head Circumference Measurements for Pediatric Referrals under the age of 2     |
| <input type="checkbox"/> Most Recent Clinic Note                                |   |
| <input type="checkbox"/> Applicable Labs or Tests                               |   |

**Requesting New Patient Appointment with:**

- N. Scott Litofsky, MD;  Fassil Mesfin, MD, PhD;  Tomoko Tanaka, MD;  
 Thorkild V. Norregaard, MD;  William Humphries, MD, MPH;  First Available

Referring Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
 City, State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Referral reason: Please check the reason for the consultation and imaging study, including date.**

- Brain  
 Brain Tumor,  Stereotactic Radiosurgery
- Cerebral vascular  
 Vascular Malformation (AVM),  Aneurysm,  Occlusion,  Dissection,  Sinus Thrombosis,  Other \_\_\_\_\_
- Functional  
 Epilepsy (VNS, surgical),  Parkinson Disease (DBS assessment, DBS battery change),  Essential tremor (DBS assessment, DBS battery change),  Spasticity (Baclofen Pump Placement, ITB battery change),  Normal Pressure Hydrocephalus,  Facial Pain/Facial spasm  Other \_\_\_\_\_
- Spine  
 Cervical:  Disk,  Stenosis,  Degenerative disease,  Tumor,  Syrinx,  Fracture  
 Thoracic:  Disk,  Stenosis,  Degenerative disease,  Tumor,  Syrinx,  Fracture  
 Lumbar:  Disk,  Stenosis,  Degenerative disease,  Tumor,  Syrinx,  Fracture  
 Other \_\_\_\_\_
- Congenital  
 Hydrocephalus,  Spina Bifida,  Cerebral Palsy,  Arachnoid Cyst,  Chiari Malformation,  Craniosynostosis,  Positional Plagiocephaly,  Pituitary Cyst,  Pineal Lesion,  Tethered Spinal Cord,  Scoliosis,  Other \_\_\_\_\_
- Traumatic  
 Concussion  Skull Fracture  Traumatic Brain Injury  Subdural Hemorrhage  Epidural Hemorrhage  
 Other \_\_\_\_\_
- Imaging Study:  
 X-ray: \_\_/\_\_/\_\_,  Brain CT: \_\_/\_\_/\_\_,  Spine CT: \_\_/\_\_/\_\_,  Brain MRI: \_\_/\_\_/\_\_,  Spine MRI \_\_/\_\_/\_\_