SELKIRK NEUROLOGY

Selkirk Neurology PLLC
610 S Sherman Suite 201
Spokane, WA 99202
509-473-0885 Office Line
509-795-0895 Fax Line

Thank you for referring your patient to Selkirk Neurology Neurodiagnostic Testing Services
This form provides our physicians and staff valuable information on patient history and symptoms
Please contact scheduling at our office with any additional questions

FAX Referral to 509-795-0895 ATTN:NEURODIAGNOSTIC TESTING REFERRAL

PATIENT INFORMATION

Last Name First Name

Date of Birth Primary/Secondary Insurance Carrier

Home Phone Number Work/Mobile Phone Number

REFERRING PROVIDER INFORMATION

Referring Practitioner

NPI# Office Fax Number

Referral Email (for results/please specify)

Practitioner Signature Date

1. EMG/NCS

☐ UPPER EXTREMITY

R L B

☐ LOWER EXTREMITY

R L B

☐ Repetitive Motion Carpal Tunnel
☐ Pain
☐ Numbness
☐ Weakness

2. EEG STUDIES

☐ *Routine EEG*

☐ *Video Ambulatory EEG*
__2 Day ___3 Day
(24 Hour)
Outpatient

☐ Recent/History of Seizure
☐ Aphasia
☐ Stroke
☐ Altered Mental Status

3. VEP/BARE/ SSEP

☐ **Audio/Visual** **Pain/Weakness** ☐

1. Signs & Symptoms Below
2. DIAGNOSIS / ICD-10
3. Do Not Include a "Rule-Out" Diagnosis

To Expedite Patient Scheduling: Ensure PCP Referral for Prior Authorizations Are Complete Before Faxing to Selkirk
INCLUDE CURRENT INSURANCE & ***RELEVANT*** RECORDS