EMU REFERRAL FORM

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Blue Sky NEUROLOGY

FAX TO: 720.287.5344

Please attach medical records with this form.
**Required.*

Patient Name:* _____

Home Phone:* _____ **Alternate Phone:** _____

Previous Monitoring:* _____ **Insurance Carrier:*** _____

ID/Policy Number:* _____ **Group/Plan:** _____

Provider Requested:

Englewood

- ☐ Kirsten Bracht, MD
- ☐ Kimberly Horiuchi, MD
- ☐ Richard Clemmons, MD
- ☐ Charles Livsey, MD, PhD
- ☐ First Available/No Preference

Wheat Ridge

- ☐ Kimberly Horiuchi, MD

Rose Medical Center

- ☐ Nathan Kung, MD

Referred For (check all that apply):

- ☐ Pre-surgical Monitoring
- ☐ Characterization
- ☐ Assessment of Current Medication Efficacy

Seizure Type (check all that apply):*

- ☐ Simple Partial
- ☐ Complex Partial
- ☐ Generalized Tonic Clonic
- ☐ Absence
- ☐ Unknown

Seizure Frequency* _____

Medication:*

Do you want meds withdrawn during EMU? ☐ Yes ☐ No ☐ Epilepsy Physician to Decide ☐ N/A

Do you want VNS turned off during EMU? ☐ Yes ☐ No ☐ Epilepsy Physician to Decide ☐ N/A

Special Needs (check all that apply):*

- ☐ Nocturnal O_2
- ☐ Wheelchair
- ☐ Interpreter
- ☐ Other_____

Prior Testing (please attach results if available):*

Last Brain MRI Date _____ Facility _____

Last Routine EEG Date _____ Facility _____

Patient Concerns:* _____

_____

Prior Auth Status:*

- ☐ Already Obtained
- ☐ Please Assist

Referring Physician:*

Physician Signature _____ Date _____