

EMU REFERRAL FORM

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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Do you want meds withdrawn during EMU?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 O₂

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 _____

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