DBS (Deep Brain Stimulation) Program

Fax completed CONSULT request form along with patient records to:
DBS Coordinators, Patient Care Programs
(615)322-0141 or (615)875-5645

Fax (615)343-6847

The Vanderbilt Movement Disorders Team would like to thank you for referring your patient for consideration of Deep Brain Stimulation Surgery. This form has been created to assist you in the referral process and to ensure that your referral is routed to the correct personnel.

PATIENT NAME: ____________________________________________

DIAGNOSIS: __________________________________________________________

DATE: ________________________________________________________________

Referring MD (Print) Referring MD (Signature)

Phone #: ______________________ Fax #: ______________________

In order to schedule an appointment for evaluation please use the following check list:

☐ AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION Signed by Patient
☐ Legible Patient DEMOGRAPHIC SHEET With Best Phone Number To Contact Patient
☐ Legible Copy of INSURANCE CARD(S) both FRONT & BACK
☐ Legible OFFICE VISIT/PROGRESS NOTES (3 MOST RECENT)
☐ *Required* MRI or CT Reports within the last 2 year
☐ Please supply all DISEASE RELATED medications tried in the past
☐ Legible most recent MEDICATION LIST
☐ May we alter medications during the consultation?

NOTE: Please allow adequate time for our physicians to review medical records. We will contact your patient upon receipt of records, notify them of referral and mail an education packet if warranted. We will advise you of appointment by fax.

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