



## Request for Consultation

**Date of Request:** \_\_\_\_\_

Please complete and send or fax all information to the Appointment Scheduler at 217-545-5878.

Your information will help facilitate the referral process.

**Requestor's Name:** \_\_\_\_\_ **Requestor's Phone:** \_\_\_\_\_

1. If there is a specific neurosurgeon you would like to see, please indicate:

Jose Espinosa, M.D.     Michael McIlhany, M.D.     H. Dennis Mollman, M.D., Ph.D.

2. If the consultation involves findings on a previous CT or MRI scan, it must be **less than 6 months old**.

If the scan is **older than 6 months**, please have the **scan(s) repeated** before the appointment.

3. Send and/or fax all **image studies (films or CDs)** and **medical records pertinent to the diagnosis** along with **this completed form**.

4. We will call your office and the patient with appointment information.

### SECTION 1: PATIENT INFORMATION Please print.

**Patient Name:** (Last, First, Middle) \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:**  Female  Male    **Social Security #:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** Home \_\_\_\_\_ Work \_\_\_\_\_ Alternative \_\_\_\_\_

**Medical Record #:** \_\_\_\_\_

If the patient has a Memorial Medical Center, Saint John's Hospital or SIU clinic medical record #, please provide.

### SECTION 2: PHYSICIAN INFORMATION Please print.

**Referring Physician's Name:** \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

How would you like to receive the results of the evaluation. Please specify.  Phone Call  Fax  Letter

### SECTION 3: REASON FOR CONSULTATION REQUEST

1. **Purpose of Consultation:**  Consultation     Confirmatory consultation (second opinion)     Consultation and Treatment

2. **Reasons for Consultation:** If the patient has a known diagnosis already, please provide and specify.

Spinal disorders: please check area(s) of problems(s)

neck pain     back pain     arm pain     leg pain     spinal stenosis     ruptured disc(s)

Other: \_\_\_\_\_

Brain tumors     Epilepsy     Hydrocephalus     Parkinson disease or movement disorder

Facial pain (i.e. trigeminal neuralgia)     Radiosurgery for: \_\_\_\_\_

Other: \_\_\_\_\_

3. **What question should the consultant answer?**

\_\_\_\_\_  
\_\_\_\_\_

Thank you for allowing us to participate in caring for your patient.

