

Request for Consultation

UT Le Bonheur Pediatric Specialists CP/Neuromuscular Clinic

Thank you for your referral to CP/Neuromuscular Clinic.

Initial referrals must come from PCP/Neurologist/Therapist/Orthopedist.

To schedule an appointment, please provide the following by fax at **(901) 937-6681**:

- This completed form
- Patient demographics AND
- Medical records related to the referral (x-ray, MRI, clinic note, etc.)

Patient Information

Patient Name: _____ DOB: _____

Phone Number: _____

Parent/Guardian: _____

Insurance: _____

Reason for Referral: _____

Has the patient been diagnosed with cerebral palsy by a Neurologist? ___ Yes ___ No

If yes, who diagnosed the patient? _____

Date of Diagnosis: _____ Has patient been diagnosed by MRI? ___ Yes ___ No

Date of last MRI: _____ Is the patient between the ages of 2-14? ___ Yes ___ No

Does the patient receive: ___ Speech Therapy ___ Occupational Therapy ___ Physical Therapy? If yes,

Where? _____

Referring Provider Name: _____ Date: _____

Phone: _____ Fax: _____

