

FUNCTIONAL NEUROLOGIC DISORDER (FND) REFERRAL FORM

Pax Medical Group, C/O Dr. Juliana Lockman M.D.

CLIENT INFORMATION

Name: _____ DOB: _____ Phone #: _____
Email: _____ Street address: _____ City/State: _____ Zip: _____ (CA only)
Insurance carrier: _____ Out-of-network benefits? ☐Y ☐N Requesting Superbill for insurance? ☐Y ☐N
(Kaiser Only, required for scheduling): Auth # _____ Expiration date: _____

TREATMENT TEAM

Referring provider: Name: _____ Institution: _____ Specialty: _____
Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

FND-Diagnosing provider: ☐ check if same as referring

Name: _____ Institution: _____ Specialty: _____
Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

Psychiatrist (required for Kaiser): ☐ check if same as referring

Name: _____ Institution: _____
Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

Therapist: ☐ check if same as referring

Name: _____ Institution: _____
Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

CONSULTATION DETAILS

Please check Functional Neurologic Disorder (FND) symptoms:

- ☐ Psychogenic non-epileptic seizures (PNES) ☐ Functional motor symptoms or paralysis
☐ Functional speech/swallow symptoms ☐ Special sensory (vision, hearing, etc.)
☐ Other (please describe): _____

NOTE: Neurologic evaluation must be complete. Referrals for patients with pending evaluation will be declined.

☐Y ☐N FND diagnosis documented in at least one clinical note. Date of note/author: _____ (required)

☐Y ☐N FND diagnosis discussed with patient. Date of note/author: _____ (required)

☐Y ☐N Documentation that patient accepts psychiatry referral. Date of note/author: _____ (required)

☐Y ☐N Neurologic exam shows "positive sign(s)" in accordance with the "incompatibility" criterion for diagnosis of FND. See for examples: *Espar AJ, Aybek S, Carson A, et al. Current Concepts in Diagnosis and Treatment of Functional Neurological Disorders. JAMA Neurol. 2018;75(9):1132-1141. Doi:10.1001/jamaneurol.2018.1264*

Positive signs/ date of note: _____

☐Y ☐N Documentation of diagnostic workup, including EMG/NCS/MRI/CT/EEG where applicable.

Study type / date(s): _____

Patients with PNES: Date/duration of EEG _____ Event captured: ☐Y ☐N

*** Please send RECORDS cited above + this form by secure fax: 408-531-6751 or secure email: consult@lockmanmd.com ***