Dr. Anne Juliana Lockman, M.D.
BOARD-CERTIFIED NEUROPSYCHIATRIST

Dear Kaiser Colleague,

Thank you for referring your client for Neuropsychiatry/Functional Neurologic Disorder (FND) telehealth consultation.

The following items must be faxed to 408.531.6751 or secure emailed to consult@lockmanmd.com prior to scheduling.

- ☐ Active Kaiser authorization for:
  Pax Medical Group
  C/o Dr. Lockman
  15732 Los Gatos Blvd Ste 3012
  Los Gatos CA 95032

  Important: Please check "NO" under "Evaluation Only" and authorize a minimum of 6 sessions with an expiration date 6 months from initial authorization date. *Please do NOT authorize Stanford or La Selva.*

- ☐ Completed FND referral form below (typically done by referring neurologist)

- ☐ Include ONLY the notes/reports you cite on the FND referral form

Please request your client contact me for scheduling ONLY after all of the above have been sent. If the client contacts me before, they will be redirected back to you to complete the steps.

Thanks, and I look forward to collaborating with you.

Kind regards,

Anne Juliana Lockman, M.D.
ABPN Board-Certified Neurologist & Psychiatrist
Director, Pax Medical Group, Inc.

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 (vison, 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: *Espay 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 *****