Intake Form for Referring Physicians

Emory Special Diagnostic Services

EMORY CLINIC

Completed Forms

Please fax completed forms to
404-778-0980
Attn: Special Diagnostics

Patient Information

First Name: _____ Last Name: _____

Mid Initial: _____ Email: _____

Date of Birth: _____ Emory Clinic Number: _____

Cell: _____ Home: _____ Alternate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Referring Provider Information

Provider Name: _____ Provider Phone: _____

Provider Address: _____

Provider Fax: _____ Provider E-mail: _____

Medical Information

1. What is the diagnostic delimma? _____

2. What is the patient's chief complaint? _____

3. What diagnoses have you considered? _____

4. How long has the patient been dealing with this illness? _____ ☐ days ☐ months ☐ years

5. Do you consider the illness to have a psychogenic cause? If yes, please elaborate. ☐ Yes ☐ No

_____

6. In the last 2 years, how many specialists has the patient seen for this complaint? _____

7. What imaging and diagnostic testing has been done related to this issue? ☐ X-ray ☐ Biopsy ☐ Ultrasound ☐ CT ☐ Nuclear ☐ MRI ☐ MRV ☐ MRA ☐ Other - describe: _____

8. Has the patient ever been hospitalized for this complaint? If yes, when and for how long? ☐ Yes ☐ No

_____

9. What treatment plans have been prescribed for this patient?

_____