UL Hospital | Multiple Sclerosis Clinic

Ambulatory Care Building
550 S. Jackson Street, 3rd Floor
Louisville, KY 40202
O: 502-561-7400
F: 502-561-7430

New Patient Intake

PATIENT NAME: _____ DOB: _____/_____/_____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Patient Insurance: _____ Member ID-GROUP #: _____

Referring MD: _____ Specialty: _____

Office Contact: _____ Phone: (_____) _____ Ext. _____

Primary Care Physician / Nurse Practitioner: _____

Diagnosis *(No diagnosis codes please)*: _____

Is this a new onset? ❑ Yes ❑ No If yes, how long? _____

Has this patient been in the hospital for this diagnosis? ❑ Yes ❑ No

If yes, when: _____/_____/_____ Where: _____

Has patient been seen by a neurologist? ❑ Yes ❑ No

If yes, when: _____/_____/_____ Name of Neurologist: _____

Has the patient had any of the following:

Radiology Imaging Type: _____ Date: _____/_____/_____ Location: _____

PT/O	❑ Yes ❑ No	Neuropsych Testing	❑ Yes ❑ No
Diagnostic Testing	❑ Yes ❑ No	Labs	❑ Yes ❑ No
Genetic Testing	❑ Yes ❑ No	Psychiatry	❑ Yes ❑ No
DBS	❑ Yes ❑ No	Botox Injections	❑ Yes ❑ No
EEG	❑ Yes ❑ No	VNS	❑ Yes ❑ No

OFFICE USE ONLY

Reviewed by: _____ Appointment Made With: _____

Date Scheduled: _____ Patient Apt/Time: _____

Date Notified _____ Packet Mailed On: _____

Date Scanned: _____ Staff Initials: _____

ALL INFORMATION ON THIS FORM NEEDS TO BE FILLED OUT IN ITS ENTIRITY. PLEASE ATTACH ANY OFFICE NOTES, LABS, TESTING AND RADIOLOGY RESULTS, PERTAINING TO REFERRAL PLEASE FAX TO 502-561-7430 ATTN: INTAKE TEAM.