Minnesota Epilepsy Group, P.A.

Magnetic Source Imaging Physician Referral Form
Attn: Mary Conroy, RN **Fax:** (651)241-2378

Patient Information: **Date:** ____/____/____

Name: _____ Handedness: _____ Gender: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: (_____) _____ Work: (_____) _____
DOB: _____/_____/_____ SS#: _____–_____–_____ Group Home? _____ Y _____N
Legal Guardian: _____ Relationship to Pt: _____Phone: (___) _____
Guardian Address: _____ State: _____ Zip: _____
Father: _____ Phone: (____) _____
Mother: _____ Phone: (____) _____

Referred by: _____ Referral made by: _____
Address: _____ Address: _____
_____ _____
Phone: (_____) _____ Phone: (_____) _____

Primary M.D. _____ Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip: _____

Pt Diagnosis: _____

Reason for Referral:

Functional Mapping:

___ Motor Mapping ___ Visual Field Mapping
___ Somatosensory Mapping ___ Language Mapping

Epilepsy:

___ Epilepsy Localization
Patient will need MRI with MSI: ___ Yes ___ No
Patient may need oral sedation: ___ Yes ___ No
Seizure Type and Freq: _____
_____
Medications: _____
Additional Information: _____
_____

Y	N

Does / did patient have:
Cardiac Pacemaker? _____
Prior Surgery? _____
Tattoos? Location:_____
Glasses / hearing aid(s)?_____
Can pt see / hear reasonably well?_____
If yes, can pt see/hear reasonably well w/o them? _____
Any metal in body (piercing, braces, plates, rods, dental caps / dental braces)? _____
_____
_____

Insurance 1_____ Insurance 2 _____
Address: _____ Address: _____
Policy Holder: _____ Policy Holder: _____
Relation to Patient: _____ Relation to Patient: _____
SS #: _____ SS #: _____
Employer: _____ Employer: _____
Claim #: _____ Grp: _____ Claim #: _____ Grp: _____
Phone: (_____) _____.Phone: (_____)

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