COLE CENTER
PARKINSON'S & MOVEMENT DISORDERS
UT MEDICAL CENTER

1975 Town Center Blvd., Suite 203
Knoxville, TN 37922
865-909-4030 (Phone)
865-909-4035 (Fax)

Patient Name: _____ **Date of Birth:** _____
Gender: _____ **Social Security**_____
Address: _____
Home Number: _____ **Mobile Number:** _____
Family/Caregiver Contact Name & Number: _____
Primary Insurance: _____ **Secondary Insurance:** _____
Referral/Authorization Required? Yes/No Is it attached? Yes/No

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Reason for Referral/ Diagnosis: _____

Primary Symptoms/Concerns: _____

Please mark if you are requesting evaluation for ◯ **DBS (wanting)** ◯ **DBS (already has)** ◯ **BOTOX**

Referring Provider: _____ Primary Care: _____
Phone: _____ Fax: _____ Phone: _____ Fax: _____
Ref. Provider Contact: _____Ext: _____

Required Referral Checklist please fax with fully completed referral form
If any necessary details/records are missing, may delay acceptance & scheduling of referral

Demographics & Insurance
☐Demographics page
☐Insurance cards front & back

Medical History & Previous Workup
☐Neurological & General Medical History (Attach relevant notes)
☐Current & Past Medications (Especially neuroleptics, levodopa formulations, dopamine agonists, or VMAT2 inhibitors)" **see attached med list" is Not Acceptable. Must list meds/therapies tried.** _____
_____
_____
_____

Relevant Imaging & Tests
☐ MRI/CT Brain (To rule out structural/secondary causes)
☐DaTscan **(**For suspected Parkinsonism)
☐Genetic Testing/Blood Work (For suspected hereditary disorders like Huntington's, SCA)

Prior Treatment & Neurology Specialist Notes
☐Neurologist/Movement Disorder Specialist Notes (If previously seen)
☐Prior Botulinum Toxin Injections (For dystonia/spasticity, if relevant)
☐Surgical Interventions (DBS, Focused Ultrasound, other procedures)

Cole Center Only

Reviewing provider notes:
_____
_____
_____
_____

Appointment Date: _____ Time: _____AM/PM **Arrive 30 minutes early
Provider: _____

Scheduler Notes: _____