FUNCTIONAL NEUROLOGIC DISORDER (FND) REFERRAL FORM

CLIENT INFO

Name: ______________________________ DOB:____________ Age:________

Address: ______________________________ City:________________ State: ____________

Insurance carrier/ID#: ______________________________

Contact Phone #: ______________________________ Email:______________________________

TREATMENT TEAM

Referring Provider:

Name: ______________________________ Institution: ______________________________

Contact Phone #: ______________ Fax #: ____________ HIPAA Secure email: ______________________

FND-diagnosing clinician name/specialty/institution (if different from referring):

____

CONSULTATION DETAILS

Please check Functional Neurologic Disorder (FND) symptoms:

□ Functional seizures

□ Functional motor symptoms or paralysis

□ Functional speech/swallow symptoms

□ Special sensory (vison, hearing, etc.)

□ Other (please describe):

____

____

____

□**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 functional seizures: Date/duration of EEG ______________________________ Event captured: □Y □N

FOR LS OFFICE USE ONLY

DATE APPROVED: ______________

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What is the difference between La Selva **residential** and **PHP/IOP** level of care?

Residential: Client lives at La Selva house in Palo Alto. Must meet severity requirements (e.g., 24/7 level care for safety, requires staff to manage meds). House is not ADA-accessible, so wheelchairs not permitted.

PHP/IOP: Client must arrange own housing. Is ADA accessible. Clients may have wheelchairs/walkers but must be independent without staff assistance.

Please complete for **all La Selva Referrals**:

□**Y** □**N** Is the client is able to ambulate independently? Assistive devices:________________________________

* Wheelchair/walker/cane accepted at PHP/IOP only

□**Y** □**N** Does the client have a warning for FND symptoms long enough to get to a safe place to prevent injury? Please describe:____

□**Y** □**N** Have there been injuries due to falls or FND symptoms themselves? If YES, please describe:

____

□**Y** □**N** Is the client willing to and able to participate in therapy groups?

□**Y** □**N** Is the client willing to disclose a statement to peers at start of program (e.g., “I have episodes which cause me to shake. I'm safe. Please allow me space to recover.")?

For **residential La Selva referrals only**, please complete the following:

□**Y** □**N** Is the client able to climb 4 stairs to get in and out of house and about 10 stairs to get up and downstairs from bedroom multiple times a day?

* First floor room may be available based on availability; no wheelchair/walker/cane

□**Y** □**N** Hygiene: Is the client able to toilet and shower independently and attend to personal hygiene?

□**Y** □**N** Meals: Is the client able to prepare light meals for breakfast?

□**Y** □**N** Chores: Is the client able to engage in some basic chores like dusting or taking out the recycling?

* There is some flexibility and accommodation with chores but other ADLs are required

SUBMISSION INFORMATION

Please fax or secure email the following as ONE PACKET to the appropriate admissions coordinator for either PHP or RTC (see https://thelaselvagroup.org/fnd-track/ for contact information):

Client face sheet with insurance info
This FND Referral Form
Recent clinical doctor’s note with supporting procedure/imaging reports

Note: Neurologic evaluation must be complete. Referrals for patients with pending evaluation will be declined.

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DATE APPROVED: _________________