Rhode Island Hospital Neuropsychiatry / Behavioral Neurology INTAKE FORM *version 5.24.17*

Date: __________________________ Screener's name: ____

Patient Name: (first)________________(middle)___________________(last)___________________ Date of Birth: ___/___/________

Street Address: ____ City, State, Zip: ________________________________

Telephone (home): _____________________ (mobile):_________________(work): ________________________

Email address: ____

Employment Status: __ Full Time __ Part Time __ Unemployed __ Homemaker __ Student __ Retired __ Disabled

Employer and address: ____

Primary Insurance: ____ Insurance ID#: _______________________________________

Subscriber Name: ____ Subscriber DOB: _____________________

Secondary Insurance: _______________________________________ Insurance ID#: _______________________________________

Referral Source/Clinician: ____ Phone #: _____________________

Primary Care Physician: ____ Phone #: ______________________

Current Neurologist: ____ Phone #: ______________________

Other Physician: ____ Phone #: ______________________

Current Psychiatrist: ____ Phone #: _____________________

Current Therapist: ____ Phone #: _____________________

Last seen by psychiatrist? _____________ Therapist? ______________ Have you ever been seen in our department before? □Yes □No

Nature of problem ***(indicate: head injury, seizures: epilepsy, nonepileptic seizures, movement disorder, memory, depression, anxiety, etc.)***

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Were you seen in a hospital? □Yes □ No Hospital name(s): ____

Was Video EEG Performed? □Yes □No Date(s): ____

If no, patients with seizures / NES <u>must</u> have a Video EEG prior to appointment. Referring physician can order VEEG by calling 401-444-4364.

(FOR OFFICE USE ONLY)

Appointment scheduled with: ____________________ Date/Time: ____

□Entered in Epic

Comments: ____

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