northwest autonomic laboratory

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Autonomic Referral Form

Patient Name: _____

Home Phone: _____ Work Phone: _____

Appt. Date: _____Time: _____a.m./p.m.

Reason for Autonomic Testing (indicating symptoms, diagnosis or check appropriate boxes below):_____

_____

_____

_____

_____

_____

Referring Physician Signature: _____

Referral Diagnosis (Please Check All That Apply)

☐ Peripheral Neuropathy	☐ Limb Pain
☐ Small Fiber Neuropathy	☐ Causalgia (RSD)
☐ Radiculopathy (Location:_____)	☐ Essential Hyperhidrosis
☐ Myelopathy	☐ Syncope
☐ Spinal Cord Injury	☐ Orthostatic Hypotension
☐ Autonomic Dysreflexia	☐ Raynaud's Syndrome
☐ Multiple System Atrophy (Shy Drager Syndrome) or OPCA	☐ Famimlial Dysautonomia (Riley Day Syndrome)
☐ Impotence	☐ Urinary Dysfunction
☐ Pure Autonomic Failure	☐ Gastrointestinal Dysfunction
☐ Tachycardia Postural Syndrom (POTS)	☐ Diabetes
☐ Hypertension/White Coat Syndrome	☐ Amyloidosis
☐ Other:_____	☐ Cancer (Type:_____)

Please check which type of visit is required:

☐ Consultation and Autonomic Testing

☐ Autonomic Testing Only (No Consultation)