Dr. Juliana Lockman, M.D.
BOARD-CERTIFIED NEUROPSYCHIATRIST

Dear Kaiser Provider,

Thank you for referring your client for Neuropsychiatry/Functional Neurologic Disorder telehealth consultation.

The following items must be faxed to 408.531.6751 or secure emailed to consult@lockmanmd.com prior to scheduling.

- ☐ Active Kaiser authorization for:
  Pax Medical Group
  C/o Dr. Lockman
  15559 Union Ave Ste 3012
  Los Gatos CA 95032

  NOTE: Please do NOT authorize Stanford or La Selva. Please check "NO" under "Evaluation Only". Please authorize a minimum of 6 sessions with an expiration date 6 months from initial authorization date.

- ☐ Completed FND referral form (typically done by referring neurologist)

- ☐ Only include the notes/reports you cite on the FND referral form

Please request your client to contact me only after the above have been sent.

Thanks, and I look forward to collaborating with you.

Kind regards,

Juliana Lockman, M.D.
ABPN Board-Certified Neurologist & Psychiatrist
Director, Pax Medical Group, Inc.

FUNCTIONAL NEUROLOGIC DISORDER (FND) REFERRAL FORM
Pax Medical Group, C/O Dr. Juliana Lockman M.D.

CLIENT INFORMATION

Name: _____ DOB:_____ Phone #: _____

Email: _____Street address: _____City/State: _____Zip: _____**(CA only)**

Insurance carrier: _____ Out-of-network benefits? □**Y** □**N** Requesting Superbill for insurance? □**Y** □**N**

(Kaiser Only, required for scheduling): Auth # _____ Expiration date: _____

TREATMENT TEAM

Referring provider: Name: _____ Institution: _____ Specialty: _____

Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

FND-Diagnosing provider: □ **check if same as referring**

Name: _____ Institution: _____ Specialty: _____

Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

Psychiatrist (required for Kaiser): □ **check if same as referring**

Name: _____ Institution: _____

Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

Therapist: □ **check if same as referring**

Name: _____ Institution: _____

Phone #: _____ Secure Fax # (for report): _____ Secure Email: _____

CONSULTATION DETAILS

Please check Functional Neurologic Disorder (FND) symptoms:

□ Psychogenic non-epileptic seizures (PNES) □ Functional motor symptoms or paralysis

□ Functional speech/swallow symptoms □ Special sensory (vison, hearing, etc.)

□ Other (please describe): _____

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

□**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 PNES: Date/duration of EEG _____ Event captured: □Y □N

***** Please send RECORDS cited above + this form by secure fax: 408-531-6751 or secure email: consult@lockmanmd.com *****