Neurological disorder questionnaire - Physician

Full name:

Application number:

1. Which neurological disorder does/did your patient suffer from?

2. When did symptoms first occur?

3. Please describe the presenting symptoms.

4. If there was more than one episode please give dates, duration and severity of each episode.

5. Please describe the current status of the disorder, including any improvement or worsening of the initial symptoms.

6. Impact of condition:

a) Is there, or has there been, any restriction or limitation on their ability to work? Yes ☐ No ☐
If YES, please provide details, including duration of any time off work in the last five years.

b) Does your patient use a wheelchair or any other form of mobility aid? Yes ☐ No ☐
If YES, please provide details.

c) Does your patient require any form of assistance with activities around the house, such as dressing, preparing food, housework, bathing? Yes ☐ No ☐
If YES, please provide details.

7. Has the patient been referred for specialist opinion or investigation? Yes ☐ No ☐
If YES, please provide full details including name, address and speciality of doctor and dates and nature of any investigations carried out or to be carried out. If still awaiting an appointment, please advise when you expect the patient to be seen.

8. Please provide details of current treatment, including names and dosages of each medication.

9. If these drugs or dosages have been changed in the last two years, please advise details including why.

10. Please comment on any other relevant features or co-morbidities which may influence the prognosis of the condition.

Signature

Date

Please print name and add clinic stamp