NEUROLOGY CENTER OF FAIRFAX, LTD.

Fairfax Office 3020 Hamaker Ct, Suite 400, Fairfax, VA 22031
Reston Office 1830 Town Center Dr, Suite 305, Reston, VA 20190
Office Phone 703.876.0800 | Fax 703.876.0866
After hours emergency 703.755.1450

Information for Our Patients

Thank you for choosing us to provide your neurological care. Our goal is to provide you with top quality care. Please help us by providing your most up to date medical information at each visit.

For each visit you **MUST**:

- Fill out all information forms (both sides) before you see your doctor. Your doctor needs current information to provide you with the best care. List your questions and concerns so they can be addressed during your visit. Multiple concerns or symptoms may require further visits.

- Complete the specific disease information sheets (i.e., Multiple Sclerosis, Parkinson's disease and Sleep) if appropriate.

- Provide a complete and up-to-date written medication list with doses and times medications are taken. Include all over-the-counter medications, vitamins and supplements.

- Get prescriptions and refills for all of your medications at the time of your visit. If you do not, you may need to return for a refill visit with our nurses. There is a charge for emergency prescription refills between visits.

- We cannot accept prescription requests from pharmacies for you due to potential medication errors. You must obtain prescriptions and refills at the time of your visit. Your prescriptions are your responsibility to be sure you receive the correct medication and the correct dose.

- To save time at your next visit, please download the necessary forms from our website www.neurologycenteroffairfax.com, or you can take forms home and fill them out ahead of time.

- Your co-payment costs, co-insurance, and any deductibles are due at the time of service. If you do not pay these costs at the time of your visit, there is a $10 administrative fee and an additional $10 service charge for each bill we send. These charges are not covered by health insurance. We accept VISA, MasterCard, Discover, cash and checks.

- Please be respectful of other patients and arrive 30 minutes before your scheduled consult time or 15 minutes before your scheduled follow up time. Please call us if you are delayed by traffic at 703-876-0800. If you are late, we may not be able to see you the same day. We understand the problems with traffic in Northern Virginia, but we cannot inconvenience patients who do arrive on time for their appointments.

- Our office does not communicate HIPAA secure information with patients via email or text messaging. You may use our web portal for secure communications with your doctor or our staff.

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Follow-Up Form

Name: _____ D.O.B.: _____ Date: _____

Primary Care Physician

Primary care doctor's name: _____

History of present illness

Height: _____ft _____in
Weight: _____lbs

Significant medical events since last visit

Other medical problems

	Problem	Start date	Status	Current treatment
1.				
2.				
3.				

Top 3 questions for visit

1.				
2.				
3.				

Medication refills needed

	Name	Strength	Frequency	
1.				
2.				
3.				

Do you have any forms to be completed by your Doctor?

**Please send forms to the office prior to your upcoming visit. Charges apply for completion of forms.*

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Parkinson's Form

Name: _____ D.O.B.: _____ Date: _____

Name of medication	Strength	Time of dose # of tablets	Any side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Compulsive behavoirs	No	Details: _____
History of glaucoma	No	Details: _____
History of melanoma	No	Details: _____

Motor symptoms in last 6 months

Tremor		None
Rigidity		None
Slowness		None
Dyskinesia/Involuntary Movement	None	
Abnormal hand/foot/truncal posturing		None

Walking symptoms in last 6 months

Shuffling		None
Start hesitation		None
Freezing		None
Imbalance		None
Assistive devices	No	Type of Device: _____
Falls	No	Fall Details: _____

Activities of daily living/dressing and showering

Needs help with activities of daily living?	No	Details: _____
Difficulty with swallowing, eating, or drinking	No	Details: _____

Associated symptoms

Constipation/diarrhea	No	Details: _____
Urinary	No	Details: _____
Sexual Dysfunction	No	Details: _____

Name: _____ D.O.B.: _____

Orthostasis	No	Details: _____
Double vision	No	Details: _____
Depression	No	Details: _____
Anxiety	No	Details: _____
Sleep disturbance	No	Details: _____
Hallucinations	No	Details: _____
Confusion	No	Details: _____
Memory loss	No	Details: _____
Speech difficulty	No	Details: _____
Slowness processing information	No	Details: _____
Other symptoms	No	Details: _____

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Medication list

Name: _____ D.O.B.:_____ Date: _____

Mail order pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Local pharmacies

Name	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

Prescriptions

If you need additional space, continue on the next page

Name	Dosage	Frequency	Reason for Taking	Prescribed by
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vitamins

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____

Over the counter medications

Name	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Name	Severity
_____	_____
_____	_____

Additional Medications/Vitamins/OTC:

Name	Dosage	Frequency	Reason for Taking	Prescribed by