Movement Disorders Program
DBS referral form

Patient name and ID, primary MD.
Attach sticker

<table>
<tr><td>Diagnosis</td><td>PD ☐ ET ☐ Dystonia ☐

Course (x years)</td></tr>
<tr><td>Previous treatment</td><td>PD meds trialed,

current PD medications dosage and frequency

Failed ET meds

Botox / xeomin for dystonia and medical treatment</td></tr>
<tr><td>Indication(s)

(please check)</td><td>
<table>
<tr><th>PD *</th><th>ET</th><th>DYSTONIA</th></tr>
<tr><td>Motor fluctuation</td><td>Failed medical treatment</td><td>Failed medical and Botox treatment</td></tr>
<tr><td>Disabling dyskinesia</td><td>Disabling tremor</td><td>Functional impaired from dystonia</td></tr>
<tr><td>Painful dystonia</td><td></td><td></td></tr>
</table>
*patient must respond to PD medications
</td></tr>
<tr><td>Any Contra-indications</td><td>Dementia ☐

Untreated depression ☐</td></tr>
<tr><td>Comorbiditie s</td><td></td></tr>
<tr><td>Function status</td><td></td></tr>
<tr><td>Goal for treatment</td><td></td></tr>
<tr><td>Comments:</td><td></td></tr>
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