PEDIATRIC NEUROLOGY CLINIC

REFERRAL FORM

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PATIENT INFORMATION

LAST NAME:		DATE OF BIRTH:	
FIRST NAME:		PHONE NUMBER:	
HEALTH CARD #		ALTERNATE PHONE:	
ADDRESS:			
EMAIL:		ALTERNATE EMAIL:	

PROVIDER INFORMATION

REFERRING INDIVIDUAL:		AREA OF SPECIALTY:	
BILLING NUMBER:		PHONE NUMBER:	
		FAX NUMBER:	
ADDRESS:		SIGNATURE:	

REASON FOR REFERRAL

Please provide a brief history:

☐ Has patient been seen by another neurologist previously

☐ Is the purpose of this referral for a second opinion?

URGENCY

☐ ROUTINE

☐ PRIORITY

☐ URGENT

If marked as URGENT, please outline the reason for urgency. Urgent patient referrals will be reviewed and triaged at the discretion of our Neurologists. We will not process the referral if it is marked urgent and no reason provided.

Please include ALL relevant reports

- Recent labs
- EEG(s)
- Imaging (Head Ultrasound, CT, MRI)
- Reports from other Specialists involved in the patient's care

Please fax <u>completed</u> referral and relevant reports to 905-844-9444
We will contact patients/families directly with a date and time of their appointment

Tel: 905.844.7444
Fax: 905.844.9444

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