General Neurology Referral Form

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Please fill out all sections below

Date: _____

PATIENT INFORMATION

Name:	M ☐ F ☐	WOH MRN (if available):
Address:		
DOB (DD/MMM/YY):	Phone Number:	
Health Card Number **(required)**:	VC	English Speaking: Yes ☐ No ☐

REFERRING PHYSICIAN INFORMATION

Name:	OHIP Provider # **(required)**
Address:	
Phone Number:	Fax Number:
Physician Signature: _____	

If the referring physician is not the family physician, please fill out the following information:

Family MD Name:	Family MD Fax Number:

REASON FOR REFERRAL

NOTE: Referrals for isolated PAIN management will be declined

Symptoms (please describe below)

☐ Weakness	☐ Headache	☐ Stroke/TIA	☐ Vision/ Double Vision
☐ Sensory Symptoms	☐ Epilepsy/Seizure/Blackouts	☐ Dysarthria	☐ Aphasia/Language Diff.
☐ Dizziness/Vertigo	☐ Gait Difficulty/Falls	☐ Movement Disorder	☐ Other (describe below)

Progression: ☐ Intermittent ☐ Progressive ☐ Constant
Duration: ☐ <1 week ☐ Weeks-Months ☐ 1-3 years ☐ >3 years

Provisional Diagnosis (please describe below) _____

Clinical History:

Previous investigations, neuroimaging, medical notes and neurology consultations: ☐ Yes (please attach reports) ☐ No

Relevant Medical History and Medications

Urgency: ☐ Next Available ☐ Semi-urgent ☐ Urgent (Please call office)