SouthlakeHealth

596 Davis Drive
Newmarket, ON L3Y 2P9

Neurology Clinics

Health Record #: ______________________ Complete or place patient label here
Patient Name: *(Print first, last)* ______________________
DOB: dd / mm / yy   Age: ______   ❑ Female ❑ Male
OHIP #: ______________   Version Code: ______________
Account #: ______________   Date of Admission: dd / mm / yy

Rapid Neuro Clinic Referral Form

Please fax to 905-853-2299

If this referral is incomplete, it will be returned for clarification

Patient Name:

Patient Phone Number: **Patient Alternate Phone Number:**

Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

Indicate if seen by any of the following while in hospital:

❑ **Dr. Farah El-Sadi** ❑ **Dr. Kyle Goldberger** ❑ **Dr. Carlos Florez**

Timing of Referral:
❑ Urgent
❑ Non-Urgent

REASON FOR REFERRAL:

❑ Headaches
❑ Seizures
❑ Movement disorders (i.e. Parkinson's disease, tremors)
Please consider outside community or GP referrals should be sent directly to Aging Well – Movement Disorders Clinic
❑ Follow-up post-acute hospital stay
❑ General neurology concerns

GENERAL NEUROLOGY AND HEADACHE REFERRALS ARE NOT ACCEPTED FROM OUTSIDE COMMUNITY PROVIDERS

Comments: ____

Referring Physician Name: *(print first, last)*	**Billing #:**
Referring Physician Signature:	**Date:** dd / mm / yy
Phone Number:	**Fax Number:**