**Referral Form for Neurology Clinics;**

**General Geriatric Neurology, Movement Disorders,**

**& Spasticity Management**

**Email:** **neuroclinics@baycrest.org** **OR Fax Referral to 647-788-4886 Call: 416-785-2500 x 2332**

**Referral date (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Client Information****Name (last/first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Date of Birth (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_****Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version Code \_\_\_\_ Expiry Date: (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_****Preferred Language: English** [ ]  **Other** [ ]  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter Required? Yes** [ ]  **No** [ ] **Primary Contact (last name/first name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Relationship to client (self/SDM/POA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Address: Street Name and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Instructions: Please indicate the reason for referral and complete the medical information section and check preferred services.**  |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ] **General Geriatric Neurology** | [ ] **Movement Disorders** | [ ] **Spasticity** | **Status:**[ ] **Routine**[ ] **High Priority** | [ ] **First available appt.**[ ] **Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ only** |

**Please provide a brief history of the reason for referral and identify primary concern and comorbidities (if applicable).****Reason for Referral:** |
| **Please attach the following information:****Past Medical History****Medication List / Allergies****Test Results (including MOCA cognitive scores, lab and imaging results i.e. brain/spine MRI, other)****Relevant Consultation reports (e.g. Neurology, Geriatrics)****Infection Status: MRSA** [ ]  **VRE** [ ]  **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Coordinated Care Plan** |
|

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Family MD | Last Assessment Date | Telephone | Fax |

 |
| **Referring Source Information** |
| **Name of Referring Physician/NP/Healthcare Professional** | **Telephone** | **Fax** |
| **Signature of Referring Physician/NP/Healthcare Provider** | **Billing #** | **Date (dd/mm/yyyy)** |

**\* Required Information > referrals will be returned if incomplete**