Sunnybrook
HEALTH SCIENCES CENTRE

Harquail Centre for Neuromodulation
MOVEMENT DISORDERS REFERRAL
Please fax referrals to: **416-480-6085**
Attention: **Dr. Nir Lipsman**

PATIENT INFORMATION:	
Last name:	First name:
Address:	
Date of Birth (dd/mm/yyyy):	OHIP #: Version code:
Phone number:	Can a message be left with another person? Y/N
Alternate phone:	Email:
*Name	*Relation:
REFERRING PHYSICIAN INFORMATION:	
Physician name:	MD Billing #:
Address:	
Phone number:	Fax #:
MAIN DIAGNOSIS: Essential Tremor / Parkinson's Disease / Multiple Sclerosis	
Other (please specify):	
REASON FOR REFERRAL:	
Details of referral: Latest CRST Score and Date (if available): Number of tremor medications tried: Ambulatory: Yes/No	

Please indicate all medication(s) patient is CURRENTLY taking:

Medication	Dose	Start Date	Stop Date	Comments/Indication

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Please indicate any of the following:			
	Yes	No	Comments
Allergy to MRI Contrast			
Significant Cardiac Disease			
Impaired Renal Function			
Metal implants (cardiac stent, pacemaker, rods, etc.)			

CURRENT MEDICAL CONDITIONS:
Family history of tremor:

Has patient been assessed by a neurologist in the past?
Y/N
If yes, it is critical that we receive the previous consultations on your patient in order to provide effective consultation. Please append them to your referral.

Name of Person Completing Form:	Date: (dd/mm/yyyy):
_____	_____