Sunnybrook
HEALTH SCIENCES CENTRE

Harquail Centre for Neuromodulation
NEURODEGENERATIVE 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:	
Alzheimer's Disease :	ALS:
Other (please specify):	

REASON FOR REFERRAL:
Details of referral: Latest MMSE Score and Date (if applicable): Ambulatory: Yes/No

Please indicate all medication(s) patient is CURRENTLY taking:				
Medication	Dose	Start Date	Stop Date	Comments/Indication

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NEURODEGENERATIVE REFERRAL
Please fax referrals to: **416-480-6150**
Attention: **Dr. Nir Lipsman**

Please indicate any of the following:			
	Yes	No	Comments
Allergy to MRI Contrast			
Significant Cardiac Disease			
Impaired Renal Function			

CURRENT MEDICAL CONDITIONS:
History of Delusions or Hallucination

Has patient been assessed by a neurologist or geriatric psychiatric professional 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):
_____	_____