General Neurology Clinic Referral Form

Incomplete and illegible forms will be returned
Phone: 416-480-5200 Fax: 416-480-5354

For office use only	
Date received:	Approved by:
Triage level:	

Please review the referral guidelines for referral to avoid delays

PATIENT INFORMATION: **Sunnybrook** MRN (if available): _____

Name: _____ M ☐ F ☐

Address: _____

DOB (DD/MM/YY): _____/_____/_____ Contact phone number(s) : _____

Health card number (**required**): _____VC: _____

English speaking: Yes ☐ No ☐ If patient does not speak English a family member/friend must attend all appointments.

REFERRING PHYSICIAN INFORMATION:
Name: _____OHIP Provider number (**required**): _____
Address: _____
Phone number: _____ Fax number: _____
Confidential email (optional): _____

If the referring physician is not the family physician please provide the family doctor's name and fax number:

REASON FOR REFERRAL:

Past medical history:

Relevant previous or planned investigations and/or management:

Please include results of previous investigations, management, and consult & follow-up notes relevant to this referral. (NOTE: Blood work not necessary at this point, we will contact referring physician if required)

If applicable, please indicate the name and date of last assessment by a neurologist (inpatient/ER/clinic):