Sunnybrook HEALTH SCIENCES CENTRE

Rapid Access in Neurosurgery (RAIN) Clinic Referral Form

2075 Bayview Avenue, C-wing, ground floor, room 02 (CG02), Toronto, ON M4N 3M5
Phone: 416-480-4053 Fax: 416-480-5576 Email: RAINclinic@sunnybrook.ca

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PATIENT INFORMATION

Name (last, first): ______________________________

Age:__________ Date of Birth (YYYY/MM/DD): ______________________________

OHIP #: ______________________ Version Code: ________ Phone #: ______________________

Address: ______________________________

REASON FOR REFERRAL

Neurosurgery:

- ☐ Brain tumour
- ☐ Traumatic brain injury
- ☐ Intracranial hemorrhage (traumatic or spontaneous)
- ☐ Hydrocephalus
- ☐ **Other:** ______________________________

Spine (only applicable for referrals from External ED):

- ☐ Spinal degenerative with neurological deficit
- ☐ Spine intradural-nerve tumour
- ☐ Incidental vascular lesion
- ☐ **Other:** ______________________________

IMAGING DONE (please include report)

☐ CT head ☐ MRI head ☐ CT spine ☐ MRI spine ☐ Other: ______________________

Referrals with a concern for an underlying lesion (e.g. neoplastic, vascular malformation) should have an MRI performed or pending from the referring site to facilitate the consultation.

REFERRAL URGENCY

Please see within: ☐ 1 week ☐ 2 - 4 weeks

Referring physician name: ______________________ Referring physician fax: ______________________

Referring physician address (or hospital name): ______________________________

Referring physician email: ______________________ Referring physician billing number: ______________

Referring physician signature: ______________________ Date (YYYY/MM/DD): ______________________

COMMENTS