Sunnybrook
ALS/NEUROMUSCULAR CLINIC

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ALS Consultation + EMG/NCS Date of referral:_____

Health Card#_____VC:_____

PATIENT'S NAME:_____ E-MAIL: _____
GENDER:_____ DATE OF BIRTH_____(Month/Day/Year)

ADDRESS:_____City _____Postal Code _____

Home Number:_____ Cell Number:_____

NEXT OF KIN _____Phone Number _____
EMAIL ADDRESS:_____Cell Number _____

REFERRING PHYSICIAN:_____ **OHIP Billing #** _____
(address) _____
PHONE# _____FAX# _____

FAMILY PHYSICIAN: _____
(address) _____
PHONE# _____FAX# _____

Reason for Referral: _____
_____
_____

PLEASE NOTE: THE FOLLOWING MUST BE INCLUDED FOR CONSULTATION:

Neurology/Consult Notes, MRI report of full spine and head, EMG report, bloodwork, and pulmonary function test

Please circle yes or no regarding patient symptoms

Yes / No	*Does the patient experience any shortness of breath when lying flat?*
Yes / No	*Is the patient experiencing any headaches first thing in the morning?*
Yes / No	*Is the patient waking up short of breath at night?*
Yes / No	*Is the patient experiencing shortness of breath on exertion with no known history of lung disease?*
Yes / No	*Does the patient have a history of frequent pneumonias over the past year?*
Yes / No	*High risk of falls?*
Yes / No	*Frequent choking episodes?*

PATIENTS WILL NOT BE BOOKED WITHOUT PREVIOUS MRI OR MRI PENDING

_____
Signature

May 2022