**Referral Form for Neurology Clinics;**

**General Geriatric Neurology, Movement Disorders,**

**& Spasticity Management**

**Email:** [**neuroclinics@baycrest.org**](mailto:neuroclinics@baycrest.org) **OR Fax Referral to 647-788-4886 Call: 416-785-2500 x 2332**

**Referral date (dd/mm/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **Client Information**  **Name (last/first): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_ Date of Birth (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_**  **Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Version Code \_\_\_\_ Expiry Date: (dd/mm/yyyy):\_\_\_\_\_\_\_\_\_\_\_\_**  **Preferred Language: English  Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter Required? Yes  No**  **Primary Contact (last name/first name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Relationship to client (self/SDM/POA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Address: Street Name and Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Instructions: Please indicate the reason for referral and complete the medical information section and check preferred services.** | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **General Geriatric Neurology** | **Movement Disorders** | **Spasticity** | **Status:**  **Routine**  **High Priority** | **First available appt.**  **Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ only** |   **Please provide a brief history of the reason for referral and identify primary concern and comorbidities (if applicable).**  **Reason for Referral:** | | |
| **Please attach the following information:**  **Past Medical History**  **Medication List / Allergies**  **Test Results (including MOCA cognitive scores, lab and imaging results i.e. brain/spine MRI, other)**  **Relevant Consultation reports (e.g. Neurology, Geriatrics)**  **Infection Status: MRSA  VRE  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Coordinated Care Plan** | | |
| |  |  |  |  | | --- | --- | --- | --- | | Name of Family MD | Last Assessment Date | Telephone | Fax | | | |
| **Referring Source Information** | | |
| **Name of Referring Physician/NP/Healthcare Professional** | **Telephone** | **Fax** |
| **Signature of Referring Physician/NP/Healthcare Provider** | **Billing #** | **Date (dd/mm/yyyy)** |

**\* Required Information > referrals will be returned if incomplete**