Alliance
Specialty Care Centres

Telephone: 416-650-1911
Fax: 416-650-5735
Email: referrals@alliancemedical.ca
1881 Steeles Avenue West, Unit 204A, Toronto

Cardiology Consult	☐	Stress Test	☐
Neurology Consult	☐	EMG	☐
Internal Medicine Consult	☐	Holter	☐
Geriatric Consult	☐	ECG	☐
PAP & STI	☐	Nerve Conduction (NCS)	☐
Echocardiography	☐	Botox Injection	☐

☐ Ambulatory ☐ Wheelchair

(*print Last, First*)

Patient Name:

Street: *Apt:* *City/Town:* *Province:* *Postal Code:*

Address:

Health Card Number: Version Code:

Primary Number: ( ) *(mm/dd/yyyy)* Date of Birth:

Secondary Number: ( ) ☐ Cell ☐ Home Work ( ) Patient's Email:

☐ Cell ☐ Home ☐ Work ( )

If Voicemail **NOT** to be left check here ☐

Copy To:

☐ **EMG/NCS + Neuromuscular Consultation**

☐ Carpel Tunnel Syndrome	☐ Left	☐ Right
☐ Ulnar Neuropathy	☐ Left	☐ Right
☐ Cervical Radiculopathy	☐ Left	☐ Right
☐ Lumbosacral Radiculopathy	☐ Left	☐ Right
☐ Polyneuropathy	☐ Left	☐ Right

Reason for Referral:

Is the patient on Anticoagulants (e.g. Coumadin)? ☐ Yes ☐ No

Physician Information

Referring Physician Name: *(Please Print)* _____ Referring Physician Signature: _____

Referring Billing Number: _____

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____

Family Physician same as above ☐ Yes ☐ No If no, please provide information below:

Family Physician Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone: ( ) _____ Fax Number: ( ) _____