Alliance
Specialty Care Centres

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

Referral Form

Cardiology Consult **Neurology Consult** **Internal Medicine Consult** **Echocardiography**
Stress test **EMG** **Holter** **ECG** **Nerve Conduction (NCS)** **Botox Injection**

☐ **Ambulatory** ☐ **Wheelchair**

Patient Name: *(Print Last, First)*

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

Health Card Number: Version Code: | Date of Birth: *(dd/mm/yyyy)*

Primary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Secondary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

If Voicemail is **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: ( ) ____________