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1881 Steeles Avenue West, Unit 204A, Toronto

- | | | | | | |
|--|--------------------------|---|--------------------------|---|--------------------------|
| <input type="checkbox"/> Cardiology Consult | <input type="checkbox"/> | <input type="checkbox"/> PAP & STI | <input type="checkbox"/> | <input type="checkbox"/> ECG | <input type="checkbox"/> |
| <input type="checkbox"/> Neurology Consult | <input type="checkbox"/> | <input type="checkbox"/> Echocardiography | <input type="checkbox"/> | <input type="checkbox"/> Nerve Conduction (NCS) | <input type="checkbox"/> |
| <input type="checkbox"/> Internal Medicine Consult | <input type="checkbox"/> | <input type="checkbox"/> Stress Test | <input type="checkbox"/> | <input type="checkbox"/> Botox Injection | <input type="checkbox"/> |
| <input type="checkbox"/> Gynecology Consult | <input type="checkbox"/> | <input type="checkbox"/> EMG | <input type="checkbox"/> | <input type="checkbox"/> Iron Infusion | <input type="checkbox"/> |
| | | <input type="checkbox"/> HOLTER | <input type="checkbox"/> | | |

Ambulatory Wheelchair
(print Last, First)

Patient Name: _____

Address: Street: _____ Apt: _____ City/Town: _____ Province: _____ Postal Code: _____

Health Card Number: _____ Version Code: _____

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

Secondary Number: _____ Patient's Email: _____

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

Copy To:

- EMG/NCS + Neuromuscular Consultation**
- | | | |
|--|-------------------------------|--------------------------------|
| <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Ulnar Neuropathy | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Cervical Radiculopathy | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Lumbosacral Radiculopathy | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Polyneuropathy | <input type="checkbox"/> Left | <input type="checkbox"/> 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: () _____