**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:

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

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

☐ 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: ( ) _____