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NEUROLOGY OUTPATIENT REFERRAL
Jim Pattison Outpatient Care & Surgery Centre

Form ID: MSXX107380A New: June 2020

PHONE: 604-582-4561 FAX: 604-528-5432

PATIENT INFORMATION:

Name: ______________________________ **Sex:** __________
Last First Middle

Date of Birth: ______ / ______ / ______ (DD / MM / YYYY) **PHN:** __________

Address: ______________________________
Street City Province Postal Code

Phone: __________ **Alternate:** __________ **Email:** __________

REFERRING HEALTH CARE PROVIDER:

Name: __________ **MSP#:** __________ **Email:** __________

Phone: __________ **Fax:** __________

SPECIALTY OR TEST REQUESTED (MUST COMPLETE RELEVANT SECTIONS ON PAGE 2):

☐ General Neurology Consultation ☐ Neuro-Ophthalmology ☐ Movement Disorders
☐ Neuromuscular (including EMG) ☐ Epilepsy ☐ CNS Electrodiagnostics (EEG and/or EP)

PLEASE COMPLETE

Has this patient been seen by a neurologist previously? ☐ Yes ☐ No (if Yes, please attach consult)
Neurologist Seen: __________

COMPLETE REFERRAL INFORMATION:

Priority: ☐ Routine ☐ Urgent

Reason for Referral / Medical Urgency: __________

Relevant Medical History: __________

PLEASE INCLUDE: - Current Medication List - Relevant Test Results - Previous Relevant Consultations

Referring Health Care Provider Signature: __________ Date: __________

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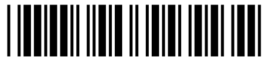

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<u>*Referrals will not be processed unless the relevant section below is complete***</u>**

GENERAL NEUROLOGY:

- If this referral is for **headache**, please attach and complete headache tool found at www.surreyheadachetool.com
- If this referral is for **stroke**, please use the Stroke Prevention Clinic Referral form (MSXX102039).

NEURO-OPHTHALMOLOGY:

☐ Consultation with Neuro-Ophthalmologist

Visual Field:

☐ Octopus Automated Perimetry 30-2	☐ Octopus Automated Perimetry 10-2
☐ Octopus (Goldmann) Binocular Driving Field	☐ Octopus (Goldmann) Kinetic Perimetry

MOVEMENT DISORDERS:

☐ Parkinson's Disease	☐ Dystonia
☐ Atypical Parkinsonism	☐ Other Movement Disorder
☐ Essential Tremor	☐ Botulinum Toxin Injection

NEUROMUSCULAR (Consultation including EMG Diagnostic Study):

☐ EMG	☐ Carpal Tunnel Syndrome ☐ Ulnar Neuropathy ☐ Peroneal Neuropathy / foot drop ☐ Polyneuropathy ☐ Plexopathy ☐ Radiculopathy	**If Radiculopathy:** ☐ Yes or ☐ No **If yes, please specify distribution of sensory loss and degree of weakness:** ______________________________ ______________________________ **If Other, please specify:** ______________________________ ______________________________

EPILEPSY:

☐ Consultation with Specialist

CNS ELECTRODIAGNOSTICS:

☐ Electroencephalography (EEG) or Evoked Potential (EP) diagnostic study (specify further below)

DIAGNOSTIC TEST REQUIRED:

☐ EEG	☐ Routine EEG	☐ Sleep Deprived EEG
☐ EP	☐ Somatosensory Evoked Potentials (SSEP)	☐ Visual Evoked Potentials (VEP)

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