fraserhealth

NEUROLOGY CLINIC REFERRAL
NEUROLOGY DIAGNOSTICS (INCLUDES EEG and EP)

FAX to JPOCSC Central Intake (604-953-9701)

PATIENT INFORMATION:

Patient's Name: ______________________ Last First Middle **Gender:** ________

Date of Birth: ____/____/______ (DD/MM/YYYY) **PHN:** ____________ **Insurance:** ________

Address: ______________________ Street City Province Postal Code

Contact Method Primary: ____________ **Alternate:** ____________

REFERRAL INFORMATION:

Priority: ☐ Routine ☐ Urgent

Date of Referral: ____________

Referring Health Care Provider:
Name: ____________
Title: ____________ **Source:** ____________
MSP #: ____________
Phone: ____________ **Fax:** ____________

Reason for Referral: ____________

Medical Reason for Urgency: ____________

Relevant Medical History: ____________

Isolation precautions ☐ Airborne ☐ Contact ☐ Droplet ☐ None

Interpreter Required No Yes If yes, specify language ____________

Referral Clinic: Neurology Diagnostics (includes EEG and EP)

Referring Health Care Provider Signature: ____________ **Date:** ____________

☐ **EEG**	☐ **Routine EEG** ☐ **Sleep deprived EEG**
☐ **EP**	☐ **Somatosensory Evoked Potentials**

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

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