Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute

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Neurology/ Epilepsy
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T: 416-603-6452
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Epilepsy Clinic Diet Referral Form

DATE: _____

PATIENT INFORMATION

PATIENT Name: _____ DOB:_____

HCN#: _____Version Code: _____ MRN#:_____

ADDRESS: _____

REFERRING PHYSICIAN INFORMATION

NAME: _____ OHIP PROVIDER #_____

ADDRESS: _____

PHONE # _____ FAX #: _____

REASON FOR REFERRAL: _____

_____

_____

MEDICAL HISTORY: _____

_____

_____

MEDICATIONS: _____

_____

LAB AND DIAGNOSTIC TESTS:
PLEASE INCLUDE THE FOLLOWING WITH YOUR REFERRAL

****RESULTS MUST BE AVAILABLE BEFORE AN APPT. IS SCHEDULED****

☐ Baseline blood work CBC, BUN, Creat, BS, Lytes, Ca, Mg, Phos, BHcg, Vit D, Amylase, AST, ALT, ALP, Carnitine level, Urinalysis, Lipid Assessment which includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Chol/HDL-C ratio

☐ Acylcarnitine level if pt. is developmentally delayed
☐ Urine Organic Acid if pt. is developmentally delayed
☐ Serum Amino Acid if pt. is developmentally delayed

☐ Baseline ECG

☐ EEG

☐ Previous Neurology Consults / follow up

☐ Brain Imaging (CT/MRI etc)

☐ Others: _____

_____ _____
Physician's Signature Date

PLEASE FAX TO 416-603-5768 COMPLETED FORM

PLEASE NOTE: INCOMPLETE REFERRAL FORMS WILL NOT BE PROCESSED AND THE PATIENT WILL NOT BE GIVEN AN APPOINTMENT. PLEASE ATTACH ANY RELEVANT PATIENT RECORDS THAT MAY BE OF HELP. IF ANY NEUROIMAGING HAS BEEN PERFORMED, PLEASE FORWARD THE FILMS/CD TO US.

Thank you for your referral and consideration. We look forward to working with you and your patients.

FOR OFFICE USE ONLY	
Date received:	Date Approved by EB:
Tentative Appointment:	