2SLGBTQIA+
NEUROLOGY CLINIC
REFERRAL FORM

2SLGBTQIA+ NEUROLOGY CLINIC
NEUROLOGY DEPARTMENT
TORONTO WESTERN HOSPITAL
399 BATHURST ST, 5- WEST WING
TORONTO, ON M5T 2S8
FAX: 416-603-6402
PHONE: 416-603-5232

DATE: _____

PATIENT DEMOGRAPHICS:

PLACE LABEL HERE

LAST NAME: _____

FIRST NAME: _____

PREFERRED/CHOSEN NAME: _____

DATE OF BIRTH: _____

MRN: _____

OHIP: _____ VERSION CODE: _____

PHONE: _____

MAILING ADDRESS: _____

IS AN INTERPRETER REQUIRED? If yes, please specify language. _____

REASON FOR REFERRAL (Please be specific):

_____

_____

_____

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_____

_____

_____

Please include all relevant information with the referral, including past medical history, surgical history, any history of injury, up-to-date list of medications, previous neurology consultation notes, neuroimaging reports, and relevant test results.

FULL NAME OF THE REFERRING MD (STAFF) / NP: _____

REFERRING MD/NP'S PHONE NUMBER: _____

REFERRING MD/NP'S FAX NUMBER: _____

OHIP BILLING #: _____

SIGNATURE: _____

Please make sure to complete ALL sections on this referral form AND include any relevant documents. Incomplete or illegible referrals will not be accepted. Thank you for your time and cooperation.