Neurophysiology Clinic
Lyndhurst Centre
520 Sutherland Drive, Toronto, ON M4G 3V9
Tel.: 416-597-3422, ext. 6591
Fax: 416-597-7042

UHN Toronto Rehabilitation Institute

PATIENT INFORMATION	**REFERRING PHYSICIAN**
Name:_____ Sex: Female ☐ Male ☐ Address: _____ _____ _____ Phone # (Home): _____ (Business): _____ Date of Birth: _____ /_____ /_____ (dd//mm/yy) health Card #: _____ WSIB #: _____ N/A ☐	Name: _____ Address: _____ _____ _____ Phone#: _____ Fax #: _____ Billing #: _____ Date of Request: _____ /_____ /_____ (dd//mm/yy)

REFERRAL FOR THE FOLLOWING:

- ☐ SSEPs only
- ☐ EMG/Nerve Conduction Studies only
- ☐ EMG/Nerve Conduction Studies and SSPEs only
- ☐ Consultation and SSEPs
- ☐ Consultation and EMG/Nerve Conduction Studies
- ☐ Consultation, EMG/ Nerve Conduction Studies and SSEPs

ANATOMIC AREA(S) TO BE TESTED:

☐ Upper extremity ☐ Lower extremity
☐ Right side ☐ Left side

URGENCY OF THE TEST/CONSULTATION:

☐ Urgent ☐ One month ☐ As available

DIAGNOSIS:

☐ Spinal cord injury/lesion ☐ Multiple Sclerosis ☐ Other (please, specify):_____

Brief Clinical History:

_____

_____

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Please, state your specific question:

_____

To assist in timely and accurate care, please include all of the following that apply:
CURRENT MEDICATION LIST, INVESTIGATIONS TO-DATE and CONSULT NOTES FROM OTHER SPECIALISTS – for example

- CT, MRI, X-Rays
- Prior electrodiagnostic studies
- Other consults with specialists

	Yes	**No**	**(Reports to follow)**
Has the list of current medications been included with this referral?	○	○	
Have the reports of prior investigations/consults been included with this referral?	○	○	

Signature of Physician: _____ Date: _____ /_____ /_____