OUTPATIENT NEUROLOGY CLINIC REFERRAL

PETERBOROUGH REGIONAL HEALTH CENTER | LEVEL 4 | FAX: 705-876-5172

PATIENT LABEL

PATIENT INFORMATION (or attach patient label)		
Name:	Date of Birth (MM/DD/YYYY):	Phone Number:
Address:	OHIP Number:	

URGENCY: Please note all referrals will be triaged by the neurologist	
☐ Urgent (1-3 weeks)	☐ Routine (next available)

REASON FOR REFERRAL (please provide as much detail as possible):

☐ Consultation following hospital discharge ☐ Consultation following ER visit

PLEASE NOTE: For neurology consultation with electromyography (EMG) please use the EMG requisition form

PLEASE ATTACH THE FOLLOWING:

☐ Patient's medical history	☐ CT result
☐ Patient's list of medications	☐ MRI result
☐ Discharge summary **or** ER physician record	☐ EEG report
☐ Other relevant medical records	☐ EMG/NCS report
	☐ Recent lab tests not done at PRHC

Date:	Referring Physician: *please print*	Billing Number:	Phone #:
			Fax #:

Medical Outpatients (MOP) will call the patient to book the appointment.
If patient has not heard from MOP, please have patient call 705-743-2121 x 8321

FOR MOP OFFICE USE ONLY

☐ Request further information: ☐ Book: ☐ Does not meet clinic criteria:	Physician signature: