

Request for Services

Referring Doctor: _____

Referring Doctor's Phone Number: _____

Referring Doctor's Fax Number: _____

Patient Name: _____ DOB: _____

MHSC Number: _____ PHIN Number: _____

Address: _____

Phone Number: _____

Service Requested:

Neurology Consultant Resource Nurse Social Work Physiotherapy

Speech Therapy Swallowing Assessment Occupational Therapy

Problem: _____

Main Reason for Referral:

Your request for degree of clinic involvement:

Take over investigation and or management of the problem above.

Provide opinion and have the patient return for ongoing management.

Other. _____

******Please enclose******

Include or summarize **all appropriate medical records** (prior consultations etc) pertaining to this patient's problem.

Investigations completed and results thereof.

Current Medication list.

Past relevant medication trials: (Please include drug name, maximal dose tried and reason for discontinuation)

Other physicians involved who should receive copies of correspondence.

Date of Request: _____

Signature: _____