FAX PATIENT REFERRAL TO:
REFERRAL MANAGEMENT SERVICES
FAX: 1-855-355-1921
PHONE: 1-833-337-7770

NEUROLOGY REFERRAL: SASKATOON

ALERT – For Emergent Referrals Present to the Emergency Room

PATIENT INFORMATION:	Last Name:	First Name:	
Date of Birth: DD/MMM/YYYY	Age:	Address:	
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:	Cell Phone:	
Requires Interpreter ☐ YES ☐ NO	Language:	Gender ☐ M ☐ F ☐ Other ☐ Undeclared	

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor	Name:
☐ Nurse Practitioner	Address:
☐ Specialist	Phone:
☐ Other (Specify)	Fax:

REFERRAL TO: ☐ **Urgent** (Explain)

☐ Next Available Specialist
Except Dr. _____

☐ Specific Dr._____
Previously seen Physician: _____

REASON FOR REFERRAL: CHECK PRIMARY REASON FOR REFERRAL AND INCLUDE RELEVANT DOCUMENTATION.

General Neurology	☐ Headache/Migraine/Facial Pain ☐ Dizziness/Vertigo ☐ Gait Dysfunction/Falls ☐ Syncope/Blackouts/Confusion	☐ Numbness/Tingling/Sensory Symptoms ☐ Visual Symptoms ☐ Other General Neurology, Specify Below
Seizures/Epilepsy	☐ New Diagnosis/First Seizure **(use Rapid Access referral form)**	☐ Known Seizure Disorder ☐ Drug Resistant Epilepsy
Neuromuscular & EMG	☐ CTS/Ulnar ☐ Polyneuropathy ☐ Cervical/ Lumbar Radiculopathy ☐ Myasthenia Gravis ☐ Myopathy	☐ Other Neuromuscular Disease, Specify Below ☐ Suspected ALS ☐ Established Diagnosis of ALS/SMA/SBMA **(please send referrals directly to ALS Clinic. Fax: #306-655-8813)**
Movement Disorders	☐ Tremor ☐ Ataxia ☐ Dystonia	☐ Parkinson's ☐ Other Movement Disorder, Specify Below
Multiple Sclerosis/ Neuroinflammatory	☐ Confirmed MS ☐ Suspected MS	☐ Other Neuroinflammatory Condition, Specify Below
Stroke/ Cerebrovascular	☐ Carotid Stenosis/Occlusion ☐ ICH	☐ TIA / Non-disabling stroke < 3 months **(use TIA/Stroke referral form and Triage Tool)** ☐ Other Cerebrovascular Disease, Specify Below
Dementia/Cognitive Changes	☐ Dementia ☐ Cognitive Changes	☐ Huntingtun's Disease ☐ Other Cognitive Disorder, Specify Below

For Triage Purposes: (Mandatory Requirement: Attach or provide detailed information explaining patient complexity, and/or previous specialist consults, bloodwork and brain or spine imaging. Please also include EEG, NCS/EMG, Holter, Echo if relevant).

POOLED REFERRAL INFORMATION: Patients offered the pooled referral option will receive the next available appointment with a specialist able to treat the referring condition. This service shares de-identified referral information with all the specialists in this group to aid in reducing patient wait times and improve the patient experience.

Physician Signature:	Date:
Redirecting Specialist: ☐ Pooled ☐ Specific Dr.	Date: