

The Pamela & Paul Austin Centre for Neurology & Behavioral Support

Baycrest Kimel Family Building, First Floor, 3560 Bathurst Street, Toronto, ON. M6A 2E1 CANADA

Referral Form for Neurology Clinics;

## Geriatric General Neurology, Movement Disorders

## & Spasticity Management

Email: <u>neuroclinics@baycrest</u>	<u>.org</u> OR Fax Ref	ferral to 647-788-4886 Call: 647-788-2727		
Referral date (dd/mm/yyyy):				
Client Information				
Name (last/first):	Gender:	Date of Birth (dd/mm/yyyy):		
Health Card #:	Version Code	_ Expiry Date: (dd/mm/yyyy):		
Preferred Language: English $\Box$ Other	□	Interpreter Required? Yes 🗆 No 🗆		
Primary Contact (last name/first name)		Phone #:		
Relationship to client (self/SDM/POA)Email:Email:				
Address: Street Name and Number:				
City:	Province	e Postal Code:		
Instructions: Please indicate the reason for referral and complete the medical information section and check preferred services.				
	Status: □Routine □High Priority	□First available appt. □Dr only		
Please provide a brief history of the reason for referral and identify primary concern and comorbidities (if applicable).				
Reason for Referral:				

3560 Bathurst St. Toronto, Ontario M6A 2E1 Canada T: 416 785 2500 W: baycrest.org Baycrest is fully affiliated with the University of Toronto



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Please attach the following information:				
Past Medical History-				
Medication List/ Allergies-				
Test Results (includingMOCAcognitive scores, laband imaging results i.e. brain/spine MRI, other)				
Relevant Consultation reports (e.g. Neurology, Geriatrics)				
Infection Status: MRSA 🗆 VRE 🗆 Other:				
CoordinatedCarePlan				
Telephone	Fax			
Referring Source Information           Name of Referring Physician/NP/Healthcare         Telephone         Fax				
Telephone	Fax			
Billing #	Date (dd/mm/yyyy)			
	eriatrics) ner: Telephone ing Source Informat Telephone	eriatrics) her: Telephone Fax ing Source Information Telephone Fax		

\* Required Information > referrals will be returned if incomplete

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