PERIPHERAL NEUROPATHY AND RELATED DISORDERS REFERRAL - DR. STEVEN BAKER

Contact booking desk at **905-521-2100 x76946** for any further questions

Please fax **completed** forms to:

905-521-2656.

M#: ______________________________

Patient Information

Name: ____

DOB: ________________ ___Male ___Female

Health Card #:______________________________ (OHIP)

Address: ______________________________________

City: ________________ Postal Code: ___________

Telephone # 1: __________________________________

Telephone #2: __________________________________

Family Physician: ________________________________

Referring Physician Information

Name: ____

Address: ______________________________________

Postal Code: ________________

Telephone: ________________

Fax: ______________________

Physician Billing #: ______________________________

Signature: ___________________________________

REASON(S) FOR CONSULTATION (*Please select all that apply)*

☑ Consult and EMG

□ Weakness

□ Amyloidosis

□ Numbness

□ Spasticity of unknown origin

□ Hereditary neuropathy: □ pos. family Hx □ neg. family Hx

□ HSP / SPG

□ Abnormal NCS / EMG

□ Other____

□ Next Available

□ Urgent

□ Patient previously seen in NM Clinic. Year _______________

Details of Referral *(frequency of symptoms, other signs and symptoms):*

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Medications: ____

Please attach all supporting information and results of tests ALREADY completed.

Please note that Dr. Steven Baker will triage appointment requests.

PERIPHERAL NEUROPATHY CLINIC OFFICE USE ONLY

Dr. Baker's Notes: ____

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□ Consult and EMG __________________________

□ Strength Test: ____________________________

□ 4U__________________________________

□ Skin Biopsy ______________________________

□ OTHER________________________________

Received: ________________________________

□ Referral not appropriate for NM/PN Clinic