2-230 Osborne St.
Winnipeg, MB R3L 1Z5
PH: 204-287-5222
Fax: 204-287-5223

NEUROLOGY REFERRAL

Provider Name: _____
Family Physician: _____
Clinic/Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____
Date: _____

PATIENT INFORMATION

Name: _____
PHIN: _____MHSC:_____ ☐ Male
DOB (dd/mm/yy): _____ ☐ Female
Address: _____ ☐ Other: _____
_____ City: _____
_____
Province: _____ Postal Code: _____
Email: _____
Home Phone #: _____
Cell #: _____ Work: _____

Referral to: Dr. Aidin Shariatzadeh

1) APPOINTMENT

☐ **Urgent** ☐ **Semi – Urgent** ☐ **Elective**

2) REASON FOR REFERRAL (Check all that apply)

☐ **Stroke**
☐ **Epilepsy/Seizure**
☐ **Loss of Consciousness**
☐ **MS (Multiple Sclerosis)**
☐ **Vertigo**
☐ **Myasthenia Gravis**
☐ **Headache**
☐ **Other: _____**

☐ **Please include recent and relevant medical history, medication records, investigations, lab results, and abnormal diagnostic results. Check box if attached.**

****Diagnostic testing may be performed at the Neurologist's discretion****

($): Fees may apply for uninsured services

This referral will be triaged. For prompt booking, please ensure all sections are fully completed.

Signature: Date: