

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

Fax: 204-287-5223

NEUROLOGY REFERRAL PATIENT INFORMATION

Family Physician: PHIN:MHSC: Male Clinic/Hospital: DOB (dd/mm/yy): Female Address: Other: Phone: Fax: Province: Postal Code: Date: Email: Home Phone #:	Provider Name:	Name:
Address:		
Address:	Clinic/Hospital:	DOB (dd/mm/yy): Female
Phone: Fax:		Address: Other:
Fax: Province: Postal Code: Date: Email: Home Phone #:		City:
Email:		
Referral to: Dr. Aidin Shariatzadeh 1) APPOINTMENT Urgent Semi – Urgent Elective 2) REASON FOR REFERRAL (Check all that apply) Stroke Myasthenia Gravis Epilepsy/Seizure Headache Loss of Consciousness Other: MS (Multiple Sclerosis) Vertigo Please include recent and relevant medical history, medication records, investigations, lab results, and abnormal diagnostic results. Check box if attached.		
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2) REASON FOR REFERRAL (Check all that apply) Stroke		
☐ Stroke ☐ Myasthenia Gravis ☐ Epilepsy/Seizure ☐ Headache ☐ Loss of Consciousness ☐ Other:	☐ Urgent ☐ Semi – Urgent	☐ Elective
□ Epilepsy/Seizure □ Headache □ Loss of Consciousness □ Other:	2) REASON FOR REFERRAL (Check all that apply	y)
□ Epilepsy/Seizure □ Headache □ Loss of Consciousness □ Other:	☐ Stroke ☐ N	Myasthenia Gravis
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abnormal diagnostic results. Check box if attached.	☐ Vertigo	
Diagnostic testing may be performed at the Neurologist's discretion		
	Diagnostic testing may	be performed at the Neurologist's discretion
(\$): Fees may apply for uninsured services	(\$): Fees n	nay apply for uninsured services
This referral will be triaged. For prompt booking, please ensure all sections are fully completed.	This referral will be triaged. For prom	npt booking, please ensure all sections are fully completed.
5 , ,		
Signature: Date:	Signature:	Date: