ALS Clinic Referral Form

McMaster University Medical Centre
1200 Main Street West, 4U
Hamilton, Ontario L8N 3Z5
905-521-2100 ext. 76365
www.hamiltonhealthsciences.ca/als

Complete Form • ATTACH REQUIRED DOCUMENTS • Fax to: *905-521-2656*

Date: _____

Patient Information – Name, Address, DOB – print clearly or affix label

Last: _____ First: _____

Apt.: ____ Address: _____

City: _____ Prov.: _____

Postal Code: _____ Tel: home: _____ cell: _____

Health Card # or IFH or UHIP: _____

Gender: Male or Female Date of Birth: _____
(dd/mmm/yyyy)

Non-English patients – Language spoken: _____ Interpreter required: yes [ ] no [ ]

Referring Physician (PRINT CLEARLY): _____ **Billing #: _____**

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Tel: _____ Fax: _____

Family Doctor – if different than referring: _____

Please attach the following with the ALS Clinic Referral Sheet:

Neurology Notes
Consult Notes
MRI Reports (date if MRI pending _____)
EMG reports
Bloodwork
Pulmonary Function Tests

Comments:

_____
_____
_____
_____