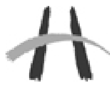
Hamilton Health Sciences

NEUROVASCULAR INTERVENTIONAL PROGRAM – GENERAL SITE PATIENT REFERRAL

Date: (yyyy/mm/dd)

Patient's Last Name First Name
Address
City Province Postal Code
ID Number HIN
Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F
Family Physician

IF THIS IS A MEDICAL EMERGENCY SEND THE PATIENT TO THE NEAREST EMERGENCY DEPARTMENT OR CONTACT THE NEUROSURGEON ON CALL THROUGH CRITICALL 1 800-668-HELP (1-800-668-4357)

The following information **is to be completed by the Referring Physician.** If you have questions regarding the referral process call 527-4322 ext 44264 (Monday to Friday 0830-1630)

Referring Physician: (Print) ____________________ (Signature & Designation) ____________________

Reason for Referral:

☐ Known/Incidental Head or Neck vascular Aneurysm
☐ Known AVM (Spinal or Brain)
☐ Carotid Stenosis
☐ Cranial/Spinal Dural Fistula
☐ ____________________

Symptoms: ____________________

Risk Factors: (Check (√) all that apply)

☐ Hypertension
☐ Hyperlipidemia
☐ Diabetes
☐ Ischemic Heart Disease
☐ Current Smoker
☐ History of Atrial Fibrillation
☐ Previous Stroke or TIA
☐ Family History

Tests Done: **(<u>Do Not</u> hold referral if labs not arranged or completed)**

☐ CT: Date (yyyy/mm/dd) ____________
Location ____________

☐ MRI: Date (yyyy/mm/dd) ____________
Location ____________

Results: ____________________

☐ Serum Creatinine (within 3 months) ________

For Imaging done outside of Hamilton, patient is to bring copies of ALL imaging to appointment

Recent Emergency Department / Hospital Care

Admit Date (yyyy/mm/dd) ____________

Facility: ____________

Location: ____________

Include copies of any related reports, tests or exams.

Patient's home phone: ( ) - **Work or alternate phone:** ( ) -

FAX TO 905-527-0059 - PATIENT WILL BE CONTACTED FOR APPOINTMENT

EL 712529 (2011-10)

Admissions - Referrals