Hamilton Health Sciences

NEUROMODULATION PROGRAM PATIENT REFERRAL

Hamilton General Site **Phone -** 905-521-2100 ext. 46755
Fax 905-527-0059

Referring Physician _____ _____
Printed Name Signature

Phone _____ Fax _____

Referral Date: (yyyy/mm/dd) _____

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

Reason for Referral: ☐ **Spinal Cord Stimulation Therapy** ☐ **Intrathecal Lioresal (Baclofen) Pump**

Clinical Indications:
- ☐ Spasticity- Spinal Cord Origin
- ☐ Spasticity- Cerebral Origin
- ☐ Traumatic Brain Injury
- ☐ Complex Regional Pain Syndrome
- ☐ Refractory Neuropathic Pain
- ☐ Other_____

Symptoms and Current Issues: _____

Past History: _____

Investigations and Imaging: (Include copies of reports)

Other treatment strategies and effects:

Current Relevant Medications:

☐ Currently on Anticoagulant: _____

Physiatry Input (reports): _____

Discharge Plan: _____

Allergies and Adverse Drug Reactions (Including Surgical Contraindications): _____

All referrals MUST be complete and submitted with relevant clinic notes, investigations and imaging reports.

Please fax legibly completed form and accompanying documentation to 905-527-0059. If you require any clarification, please contact 905-521-2100 x - 44251 (Monday to Friday, 08:30 – 16:30). Patient will be contacted for appointment.