PERIPHERAL NEUROPATHY AND RELATED DISORDERS REFERRAL

McMaster Children's Hospital

Contact booking desk at **905-521-2100 x76377** for any further questions

Please fax **completed** forms to:

905-521-2638

M#: _____

Patient Information

Name: _____

DOB: _____ ___Male ___Female

Health Card #:_____ (OHIP)

Address: _____

City: _____ Postal Code: _____

Telephone # 1: _____

Telephone #2: _____

Family Physician: _____

Referring Physician Information

Name: _____

Address: _____

Postal Code: _____

Telephone: _____

Fax: _____

Physician Billing #: _____

Signature: _____

REASON(S) FOR CONSULTATION (*Please select all that apply)*

☑ Consult and EMG

□ Weakness

□ Numbness

□ Spasticity of unknown origin

□ Hereditary neuropathy: □ pos. family Hx □ neg. family Hx

□ HSP / SPG

□ Abnormal NCS / EMG

□ Amyloidosis

□ Other_____

□ Next Available

□ Urgent

□ Patient previously seen in NM Clinic. Year _____

Details of Referral *(frequency of symptoms, other signs and symptoms):*

_____

_____

_____

Medications: _____

Please attach all supporting information and results of tests ALREADY completed.

Please note that Dr. Steven Baker will triage appointment requests.

PERIPHERAL NEUROPATHY CLINIC OFFICE USE ONLY

Dr. Baker's Notes: _____

_____

_____

_____

□ Consult and EMG _____

□ Strength Test: _____ □ 4U_____

□ Skin Biopsy _____ □ OTHER_____

Received: _____ □ Referral not appropriate for NM/PN Clinic