

REFERRAL FOR CONSULTATION == NEUROLOGY CENTRE OF TORONTO (NCT) ==

♦ Evan Lewis, MD, FRCPC ♦ Koorosh Shirkoool, MD, FRCPC ♦ Yue Jiang, MD, FRCPC ♦
♦ Ervin Leroy Johnson III, MD, PhD ♦ Johann Micallef, MD

PATIENT CONTACT INFORMATION

Last Name:	First Name:	Date of Birth:
OHIP #:	Version Code:	
Street Address:	Unit #:	City:
Postal Code:	Home Phone:	Mobile Phone:

REASON FOR REFERRAL

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Concussion/Post-Concussion | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Neuromuscular | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tics/Abnormal Movement | <input type="checkbox"/> Other |
| <input type="checkbox"/> Rare Disease Clinic | | | |

Allied Health: Psychotherapy Nutrition Occupational Therapy (OT) Physiotherapy (PT) Massage Therapy

REFERRAL INFORMATION: include relevant laboratory, imaging, neurophysiology results, etc.

URGENT: NON-URGENT:

Contact admin@neurologycentretoronto.com for all urgent requests

Referring Individual:	MRP CPSO Number (physicians):
Most Responsible Practitioner (MRP):	MRP Billing Number (physicians or NPs):
MRP Contact Information (Name of Practice, Address, Phone & Fax):	
MRP Signature:	Current Date:

*Send completed consultation requests to Neurology Centre of Toronto (NCT) by
Fax: 416.860.7559 or Email: admin@neurologycentretoronto.com*