NORTH YORK NEUROLOGY

Tel: 416-247-4947 Fax: 365.525.2000
bookings@gmdclinic.ca

2221 Keele Street, Suite 301
North York, ON
M6M 3Z5

REFERRAL FORM CAN BE FAXED THROUGH TO 1.365.525.200

Date of Referral:_____**Urgent:** ☐ **Yes** ☐ **No**

Patient Full Name:_____

Patient Address:_____

_____

Health Card Number:_____

Patient Phone Number:_____

Date of Birth (yyyy-mm-dd):_____

Referring Physician Name:_____**BILLING #:**_____

Tel:_____ **Fax:**_____ **Signature:**

☐ Disorder of Abnormal Movement ☐ Epilepsy and Seizures ☐ Headaches ☐ Tremors

☐ Disorders of Memory and Cognition ☐ Consultation, EMG, and Management

☐ Other _____

Reason for Referral (additional information): If applicable, please include with the referral:

☐ Previous Blood Work ☐ Diagnostic Imaging ☐ Consultation Letters

AdditionalComments:_____

Referring Physicians will be notified within 2 weeks of receipt and patient will be notified of the appointment directly.