ALBERTA NEUROLOGIC CENTRE

ALBERTA NEUROLOGIC CENTRE
Suite 300, 1608 17th Avenue SW, Calgary, Alberta, T2T 0E3
Phone: 587-747-5615 Fax: 587-747-5616
www.ancentre.ca

PHYSIATRY REFERRAL FORM

Dr. Stephen McNeil
MD, FRCPC (Physical Medicine and Rehabilitation), CSCN (EMG)

Dr. Geoffrey Frost
MD, FRCPC (Physical Medicine and Rehabilitation), CSCN (EMG)

Dr. Jacqueline Stone
BSc, BPHE, MBA, MD, FRCPC (Physical Medicine and Rehabilitation), CSCN (EMG)

Referrals will be triaged and scheduled with the first available provider

Name: ____ Date of Birth: _____________________ ULI: ____________________

Address: ____

Home Phone: _________________________ Work Phone: ________________________ Cell Phone: _________________________

REFERRAL INFORMATION

Priority

☐ **Urgent** ☐ **Routine**

For urgent requests please indicate why, or call the clinic to discuss with one of our physicians

Referring Physician

NAME: ________________________________

PRAC ID: ______________________________

Phone: ________________________________

Fax: __________________________________

Physician to Receive Copies

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EXCLUSIONS: NO TO ALL ☐ **IF THIS SECTION IS INCOMPLETE, REFERRALS WILL BE RETURNED*

Has your patient had:

- Pain in area of concern for more than 3 years
- Pain as a result of a motor vehicle accident
- Chronic opioid use for 6 or more months
- WCB claim for area of concern
- More than 10 image guided injections to the area of concern
- First line imaging for area of concern that has not been completed
- Previously attended, been referred to, or is currently attending a chronic pain clinic

CLINICAL QUESTION

☐ Spasticity/ Tone Assessment ☐ Dystonia ☐ Ultrasound Guided Injection

☐ Bracing/ Orthotics ☐ Acute MSK/ Adult Sport Injury

☐ Other ____

Relevant History and Examination: (include any relevant investigations, imaging studies, consults and prior EMG studies)

Referring Physician Signature: ___________________________ **Date:** ____________________

Please fax completed referral to ANC at ***587-747-5616***