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

MULTIPLE SCLEROSIS REFERRAL FORM

Dr. Jonathan Fridhandler
MD, FRCPC (Neurology),
CSCN (EMG)

Name: ____________________ Date of Birth____________________ ULI: ____________________

Address: ____

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

REFERRAL INFORMATION

Prior Neurologic Assessments

☐ **Yes** ☐ **No**

Prior Neurologist: ____________________

____

____

Referring Physician

NAME: ____________________

PRAC ID: ____________________

Phone: ____________________

Fax: ____________________

Physician to Receive Copies

____

____

WCB Number____________________

CLINICAL QUESTION

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

☐ **Patient has MRI of the brain within the last 2 years suggesting MS, or a previous MS diagnosis**

☐ **URGENT:** (reason for request)

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

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