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

PHYSIATRY REFERRAL FORM

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

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

Dr. Alex Wasserman
BSc, MD, FRCPC (Physical Medicine and Rehabilitation), CSCN (EMG)

Dr. Geoff Frost
MD, FRCPC (Physical Medicine and Rehabilitation)

Dr. Rehana Murani
BSc, MD, FRCPC (Physical Medicine and Rehabilitation), CSCN (EMG), Dip. Sports Med

PATIENT INFORMATION (can attach label)

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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WCB Number__________________

CLINICAL QUESTION

☐ Spasticity/ Tone Assessment
☐ Dystonia
☐ Neuromuscular Rehabilitation
☐ Bracing/ Orthotics
☐ Acute MSK/ Adult Sport Injury
☐ Ultrasound Guided Injection
☐ Neuropathic Pain Management
☐ 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***