ALBERTA NEUROLOGIC CENTRE
Suite 210, 1608 17th Avenue SW, Calgary, Alberta, T2T 0E3
Phone: 587-747-5615 Fax: 587-747-5616
www.ancentre.ca

PHYSIOTHERAPY REFERRAL FORM

Veronique St-Georges
Vestibular Physiotherapist
BSc. (Hons) PT

Jacquie Townsend
Physiotherapist
BMR PT

Name: ______________________________ Date of Birth______________________ ULI: ______________________

Address: ____

Home Phone: __________________________ Work Phone: _________________________ Cell Phone: __________________________

REFERRAL INFORMATION

Prior Neurologic and/or ENT Assessments

☐ **Yes** ☐ **No**

Prior Neurologist or Otolaryngologist:

____

Referring Physician

NAME: ________________________________

PRAC ID:________________________________

Phone: ________________________________

Fax: ________________________________

Physician to Receive Copies

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WCB Number__________________

CLINICAL QUESTION

- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ Neuromuscular disorder
- ☐ Mechanical low back pain
- ☐ Dizziness
- ☐ Imbalance
- ☐ Vertigo
- ☐ Functional neurological disorder
- ☐ Migraine
- ☐ Blurred vision
- ☐ Nausea and/or vomiting
- ☐ Hearing loss and/or tinnitus and/or fullness
- ☐ Other ________________________________

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

Referring Physician Signature: ________________________ **Date:** ______________________

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