ALBERTA NEUROLOGIC CENTRE

ALBERTA NEUROLOGIC CENTRE
Suite 300, 1608 17th Avenue SW, Calgary, Alberta, T2T 0E3
Phone: 587-747-5615 Fax: 587-747-5616
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PHYSIATRY REFERRAL FORM

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), 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

____

____

WCB Number____________________

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***