ELKIE ADLER MULTIPLE SCLEROSIS CLINIC
Baycrest – Brain Health Centre
3560 Bathurst St., Main Floor, Toronto, ON M6A 2E1
Telephone: (416) 784-3600 Fax:(416) 784-5600

REQUEST FOR NEUROLOGICAL CONSULTATION

IF NO BRADMA, Please complete Section A:

Section A:

PATIENT NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: RESIDENCE: ( ) _____

BUSINESS: ( ) _____

CELL PHONE: ( ) _____

DATE OF BIRTH: _____
Day Month Year

Section B:

HEALTH CARD: _____ GENDER: M/F

FAMILY DR: _____

ADDRESS: _____

_____

TELEPHONE: _____ FAX: _____

PLEASE INCLUDE ANY TEST RESULTS AND CURRENT DOCTORS NOTES

REFERRING DR.: _____ BILLING # _____

ADDRESS: _____

_____

_____

TELEPHONE: _____ FAX: _____

Section C:

DIAGNOSIS: _____ ☐ Unknown

REASON FOR REFERRAL:

Please include all Clinical notes, Diagnostics, Medication lists and Imaging reports/CDs for the initial consultation.

SIGNATURE: _____ **DATE:** _____