Sunnybrook
HEALTH SCIENCES CENTRE
ALS/Neuromuscular Clinic

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Office: 416-480-4213/Fax: 416-480-6817

U of T NEUROLOGY

# ALS Consultation + EMG/NCS

DATE: _____

HEALTH CARD# _____ VC: _____

PATIENT'S NAME: _____ E-MAIL: _____

ADDRESS: _____

_____

TE LEPHONE NO: _____

POSTAL CODE: _____ GENDER: _____ DATE OF BIRTH: _____

CONTACT (NEXT OF KIN): _____

**REFERRING PHYSICIAN:** _____ OHIP Billing # _____
(Address) _____

PHONE# _____ FAX# _____

**FAMILY PHYSICIAN:** _____
(Address) _____

PHONE# _____ FAX# _____

## Reason for Referral: _____

_____

_____

**<u>*PLEASE INCLUDE THE FOLLOWING:</u>**

NEUROLOGY NOTES
CONSULT NOTES
MRI REPORTS (date of MRI if pending _____)
EMG REPORTS
BLOODWORK
PULMONARY FUNCTION TEST

*** PATIENTS WILL NOT BE BOOKED WITHOUT PREVIOUS MRI OR MRI PENDING**

_____ _____
Signature Date