Providence HEALTH CARE

Place Patient Form Label Here

ST. PAUL'S IMMUNOTHERAPY IN NEUROLOGY (SPIN) CLINIC REFERRAL

* 1 0 1 9 8 *

Neurology Referral

St. Paul's Immunotherapy in Neurology (SPIN) Clinic **Location:** Neurology Department, Room 2359, Level 2 Providence Building
Phone: 604-806-8411 **Fax:** 604-806-8624

Date of Referral: (dd/mmm/yyyy) _____

PATIENT INFORMATION:

Name: _____
PHN: _____
DOB: (dd/mmm/yyyy) _____
Phone: _____
Email: _____

Gender:
☐ Male
☐ Female
☐ Other: _____

Preferred language: _____
☐ Interpreter required

REFERRING PROVIDER:

Printed name: _____ MSP #: _____
Phone: _____ Fax: _____

PRIMARY CARE PROVIDER:

Printed name: _____

URGENCY

☐ **Urgent** ☐ **Semi-urgent** ☐ **Routine**

REASON(S) FOR REFERRAL:

☐ Electromyography (EMG) and consultation ☐ Consultation only

☐ Patient seen previously by neurology / rheumatology - Physician: _____ Date: _____

DIAGNOSIS:

☐ Autoimmune Inflammatory Neuropathy ☐ Myasthenia Gravis ☐ Myositis
Other: _____

CURRENT MEDICATIONS:

☐ List attached with correspondence

INFORMATION ATTACHED:

☐ Relevant lab results over the duration of the illness
☐ Relevant consult reports from other physicians
☐ Copies of relevant imaging studies (include dates)
☐ Copies of all relevant discharge summaries

FAX completed referral and all relevant supporting documents to be triaged by SPH Immunotherapy in Neurology (SPIN) Clinic. 604-806-8624

For expedited referral (to be seen in less than two weeks) **contact Dr. Chapman or Dr. Beadon to discuss case.**