SOUTHERN ONTARIO EPILEPSY CLINIC
IMPROVING CARE THROUGH EDUCATION

For office use only

General Neurology Referral Form

Thank you for choosing Southern Ontario Epilepsy Clinic. To best serve you within a reasonable time frame please have this form filled out completely and legibly. Please send the necessary information along with the referral so that it can be appropriately triaged by. Dr. Bercovici.

PLEASE FAX COMPLETED REFERRAL FORM TO **416-620-7633**

Patient Information

Name: _____ DOB: _____

Health card number: _____ Version Code: _____

Address: _____ City: _____

Telephone #: Mobile: (_____)_____ Home/Business: (_____)_____

Reason for Referral

Reason for Referral: _____

How long as this being ongoing for:_____

Level of urgency
( ) Next available ( ) Semi-urgent ( ) Urgent: state reason: _____

Medications: _____

Past Medical history _____

_____

Referring Physician information

Name: _____ (MD / NP) Billing # _____

Address: _____

Telephone # _____ Fax # _____

Signature: _____

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