

Department of Neuroscience Referral Form

The Alfred
 Commercial Road, Prahran, 3181
 Fourth Floor, Centre Block
 Phone: 9076 2059 Fax: 9076 5075



Appointment Date: _____ Time: _____ AM/PM

Patient Details: (Block letters)

Surname:		First Name:		UR Number:	
Address:					
Date of Birth:	Ward/Unit:	IP/OP/Private	Phone Number:		

Interpreter Required: Yes / No Language: _____

Veteran Affairs Workcover TAC (Claim No: _____)

Clinical Notes:	Test Required:
	<input type="checkbox"/> EMG/NCS
	<input type="checkbox"/> EEG
	<input type="checkbox"/> VER
	<input type="checkbox"/> SER: <input type="checkbox"/> Upper <input type="checkbox"/> Lower
	<input type="checkbox"/> Quantitative Sensory Test
	<input type="checkbox"/> Autonomic Study
	<input type="checkbox"/> Visual Field
	<input type="checkbox"/> Tremor Study
	<input type="checkbox"/> Botulinum Toxin Injection (for neurological disorders)
	<input type="checkbox"/> Long Term EEG Monitoring (By Neurologist referral only)

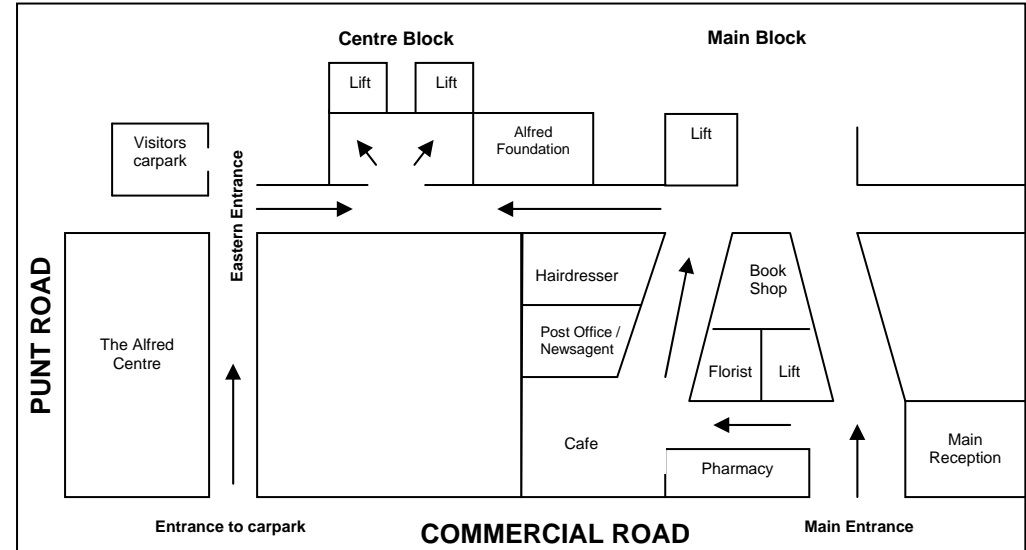
Date:	Provider Number:	Pager/Extension:

Referring Doctor:	Signature:

Report Copies To:

Directions to the Neuroscience (EEG/EMG) Department

GROUND FLOOR



FOURTH FLOOR

