ALBERTA NEUROLOGIC CENTRE

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Suite 300, 1608 17th Avenue SW, Calgary, Alberta, T2T 0E3
Phone: 587-747-5615 Fax: 587-747-5616
www.ancentrephysio.ca

PHYSIOTHERAPY REFERRAL FORM

Jacquie Townsend
Physiotherapist
BMR PT

Name: ____________________ Date of Birth: ____________ ULI: ____________

Address: ____

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

REFERRAL INFORMATION

Prior Neurologic and/or ENT Assessments

☐ **Yes** ☐ **No**

Prior Neurologist or Otolaryngologist:

____

Referring Physician

NAME: ____________________

PRAC ID: ____________________

Phone: ____________________

Fax: ____________________

Physician to Receive Copies

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CLINICAL QUESTION

☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Neuromuscular disorder ☐ Mechanical neck/low back pain

☐ Dizziness ☐ Imbalance ☐ Vertigo ☐ Functional neurological disorder

☐ Migraine ☐ Blurred vision ☐ Nausea and/or vomiting

☐ Hearing loss and/or tinnitus and/or fullness ☐ Other ____________________

Relevant History and Examination: (include any relevant investigations, imaging studies, consults)

Referring Physician Signature: ____________ **Date:** ____________

*Please fax completed referral to ANC at **587-747-5616***