

Neuromuscular Medicine Referral Form

Rebalance^{MD}

Neuromuscular and Electrodiagnostic Medicine Clinic

(Dr. Berger / Dr. Filbey / Dr. Krauss)

Phone 250 940 4444 Fax 250 385 9600

PATIENT INFORMATION: (affix label or complete) Name: PHN: DOB: Gender Identity: Address: Home Phone: Alternate Phone: Email: Secondary Contact: WCB Claim # if applicable:		REFERRING MD / NP: (affix label or complete) Name: MSP: Address: Phone: Fax: If applicable, Care Facility / Walk in Clinic Name: PRIMARY CARE PROVIDER: (if not referring MD/NP)																	
DATE OF REFERRAL:	Patients Will Be Triageed To The Appropriate Physician / Clinic based on Referral Information and Acuity. <input type="checkbox"/> First Available MD (preferred choice) Prefer to see Dr. Filbey: <input type="checkbox"/> Dr. Berger: <input type="checkbox"/>	URGENCY Severe or Rapid Progression? <input type="checkbox"/> Yes.																	
PROVISIONAL DIAGNOSIS (select as appropriate) <table border="0"><tr><td><input type="checkbox"/> Carpal Tunnel Syndrome: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Complex Nerve Injury Clinic (includes Dr. Krauss)</td></tr><tr><td><input type="checkbox"/> Ulnar Neuropathy: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Bell's Palsy / Facial Palsy</td></tr><tr><td><input type="checkbox"/> Foot Drop: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Peripheral Neuropathy (Metabolic / Genetic / Toxic)</td></tr><tr><td><input type="checkbox"/> Cervical Radiculopathy: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Balance and Gait Disorders (Peripheral/Central)</td></tr><tr><td><input type="checkbox"/> Lumbar Radiculopathy: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Myopathy / Myositis</td></tr><tr><td><input type="checkbox"/> Brachial Plexopathy: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Myasthenia Gravis / Lambert-Eaton Syndrome</td></tr><tr><td><input type="checkbox"/> Lumbar Plexopathy: <input type="checkbox"/> R <input type="checkbox"/> L</td><td><input type="checkbox"/> Motor Neuron Disease / Other NM Disorders</td></tr><tr><td><input type="checkbox"/> Other _____</td><td></td></tr></table>				<input type="checkbox"/> Carpal Tunnel Syndrome: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Complex Nerve Injury Clinic (includes Dr. Krauss)	<input type="checkbox"/> Ulnar Neuropathy: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Bell's Palsy / Facial Palsy	<input type="checkbox"/> Foot Drop: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Peripheral Neuropathy (Metabolic / Genetic / Toxic)	<input type="checkbox"/> Cervical Radiculopathy: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Balance and Gait Disorders (Peripheral/Central)	<input type="checkbox"/> Lumbar Radiculopathy: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Myopathy / Myositis	<input type="checkbox"/> Brachial Plexopathy: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Myasthenia Gravis / Lambert-Eaton Syndrome	<input type="checkbox"/> Lumbar Plexopathy: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Motor Neuron Disease / Other NM Disorders	<input type="checkbox"/> Other _____	
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URGENT REFERRALS: Patients that require Urgent Assessments – ie. suspicion of <i>Guillian Barre Syndrome, Severe / Progressive Neuropathy / Acute Painful Radiculopathy / Severe Balance Problems</i> Will be Triageed ASAP as indicated by the information forwarded.																			
REASON FOR REFERRAL: please provide any relevant information that will help with triaging.		Letter Attached <input type="checkbox"/>																	
Rapid Access CTS/ULN Nerve Clinic: (Please note Referrals to the CTS clinic will include: - referral to Appropriate Surgeon if Necessary; - Access to appropriate splinting; - Same Day POCUS injections if indicated;																			
MEDICAL & SURGICAL HISTORY: History Attached <input type="checkbox"/>		MEDICATIONS: List Attached <input type="checkbox"/>																	
		ALLERGIES: List Attached <input type="checkbox"/>																	

Please have your patient visit our Neuromuscular Clinic Section on the [Rebalance^{MD}](#) website. We will provide detailed information on the site to help them prepare for their visit.

Feel free to reach out to one of our physicians if you have any specific questions about a patient or new referral to our clinic.

Our office will be in touch with your patient to arrange a Neuromuscular Consultation in a timely manner based upon the information received.