ETOBICOKE HEADACHE CLINIC

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# Headache Management Neurological Consultation Request

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|---|---|---|
| Date of Referral: | | |
| **Patient Information** | | |
| First Name: | Last Name: | |
| D.O.B. (DD/MM/YYYY): | Gender: | |
| Health Card #: | Version: | Expiry Date: |
| Address: | | |
| City: | Postal Code: | |
| Phone Number (1): | Phone Number (2): | |

| **Reason for Referral** |
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| If prior neuroimaging is available (i.e. MRI/CT head/neck), please include it within the referral along with any pertinent labs (i.e. renal/hepatic function). |

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|---|---|---|
| **Referring Healthcare Provider Information** | | |
| Referring Provider Name: | | OHIP Billing #: |
| Address: | | City: |
| Postal Code: | Phone: | Fax: |
| **Primary Healthcare Provider (If Different from Above)** | | |
| Referring Provider Name: | | |
| Address: | | City: |
| Postal Code: | Phone: | Fax: |
| *Please note: Dr. Aleksenko is not accepting WSIB claims at this time.* | | |